The Modern Hospital

MARCH 1958

PLANNING AND BUILDING THE HOSPITAL ADDITION
Survey: what administrators think about additions and would do differently if they were building again; round table on additions; programming—page 67

HOW TO DEAL WITH THE PROBLEM OF HOSPITAL INFECTIONS
Infection rate in some hospitals has shot up to 30 per cent or more; here are rules for control; what to do to curb spread of infection in nurseries, operating rooms—page 51

WANTED: NURSES WHO WILL CARRY THEIR OWN LAMPS
Making an executive out of the graduate nurse is compounding the problem, not solving it; what we need is a two-year nurse who wants to nurse—page 58

CREDIT AND COLLECTION METHODS SHOULD BE TIGHTENED
When payments start to lag, it is time to review credit policies and collection methods; an outline of businesslike procedures that should be followed—page 63

Bays provide view for every ward patient at University Hospital, Caracas, Venezuela (Page 33)

WOODRIDGE
the beauty of wood
...the strength of steel

hospitable hospital harmony... by Royal®

Beauty *is* as beauty *does* in Royal's wonderful WOODRIDGE hospital furniture. Saves work for busy staff and attendants . . . helps hasten patient recovery!

To the home-like warmth of wood, *Royal* adds the strength of "skyscraper" steel inner-construction, plus individually replaceable panels . . . Makes for easy accessibility . . . simplifies "housekeeping" of dressers, desks, nightstands and cabinets.

Write for information and literature to:

ROYAL METAL MANUFACTURING COMPANY

One Park Avenue, New York 16, N. Y., Dept. 8-C

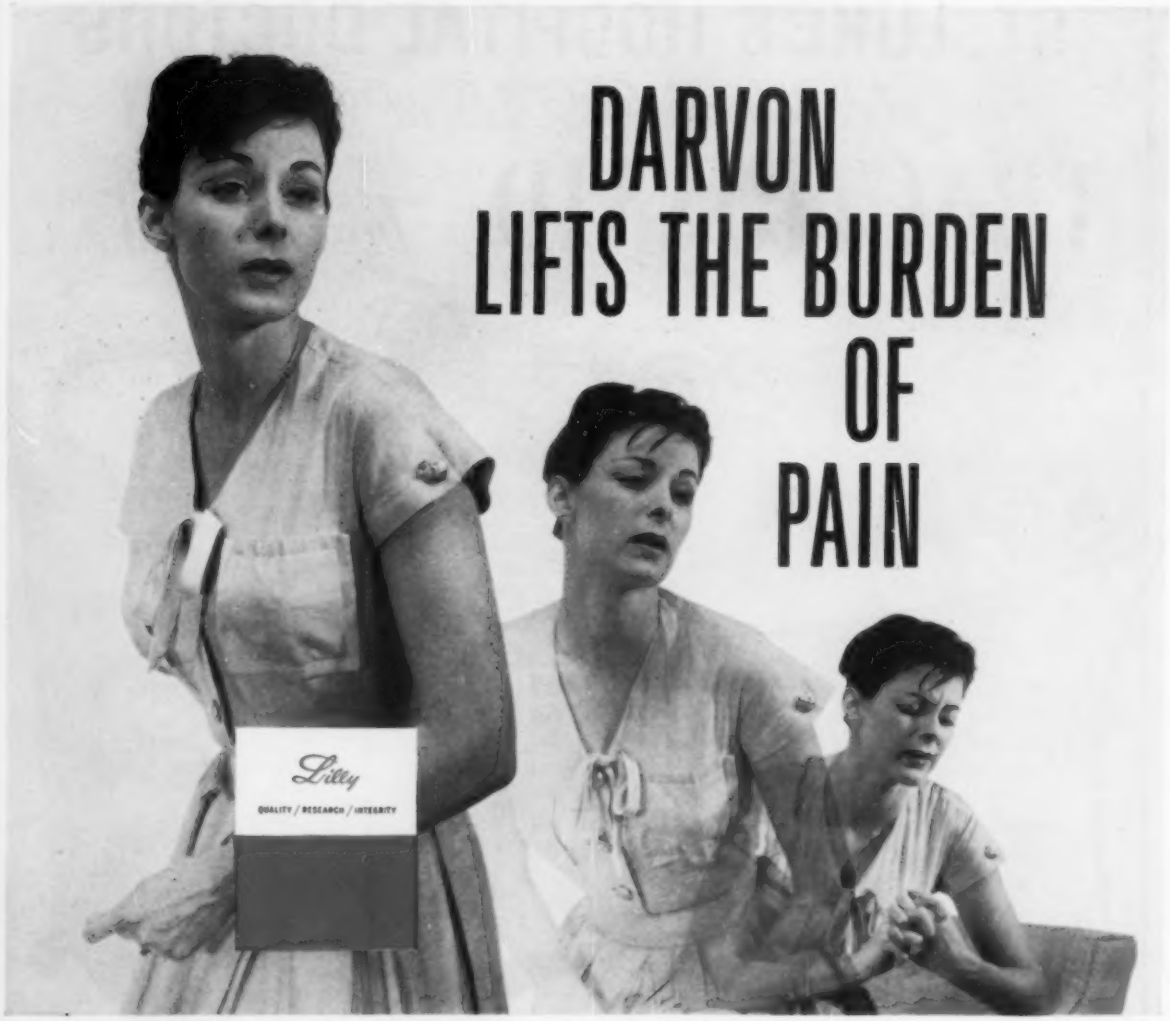
The responsive *Royal* HI-LO Bed, illustrated, raises or lowers with 25 effortless turns—simple, accessible clutch arrangement permits Trendelenburg position in 10 seconds; Fowler position in 25 seconds. Blends completely with decor and surroundings.

Royal wood-and-steel seating adds the finishing touch to pleasant patient rooms. Complete information and literature are yours for the asking. No obligation, of course.

See Woodridge . . . by Royal at:

Midwest Hospital Association Convention, Municipal Auditorium
Kansas City, Missouri, March 24-26

New England Hospital Assembly, Hotel Statler
Boston, Massachusetts, March 24-26



The non-narcotic analgesic with the potency of codeine

DARVON (Dextro Propoxyphene Hydrochloride, Lilly) is the unique analgesic which is equally as potent as codeine yet much better tolerated. Side-effects, such as nausea or constipation, are minimal. Orally effective, 'Darvon' is valuable in any disease associated with pain. There is no loss in analgesic potency.

'Darvon' is available in 32 and 65-mg. pulvules.

DARVON COMPOUND (Dextro Propoxyphene and Acetylsalicylic Acid Compound, Lilly) further increases effectiveness by combining the analgesic action of 'Darvon' with the antipyretic and anti-inflammatory benefits of 'A.S.A. Compound' (Acetylsalicylic Acid and Acetophenetidin Compound, Lilly).

Contraindications have not been reported.

Each Pulvule 'Darvon Compound' provides:

'Darvon'	32 mg.
Acetophenetidin	162 mg.
'A.S.A.' (Acetylsalicylic Acid, Lilly)	227 mg.
Caffeine	32.4 mg.

Supplied in bottles of 100.

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

620264

The Modern Hospital

MARCH 1958 VOLUME 90, NO. 3

Articles in this issue

Management Problems Stressed at A.C.H.A. Congress
Attendance exceeds expectations at the first educational session of the college of hospital administrators. Automation, scientific management and a bevy of practical problems fill the two-day program.....49

What to Do About Hospital Infections JANE BARTON
The first step in combating staphylococcus infection is to recognize that the problem exists. Subsequent procedures include an infections committee, better observance of aseptic technics, a probe for carriers.....51

Colors and Balconies Enliven Venezuelan Hospital
An accordion layout of beds in the wards of University Hospital in Caracas affords every patient a view and maximum privacy.....55

Wanted: Nurses Who Carry Their Own Lamps EDITH A. AYNES
A give-and-take discussion reveals the need for a good two-year-trained bedside nurse to fill the gap between the practical nurse and the R.N. whose training qualifies her for ultimate administrative responsibility.....58

How to Collect Good Will With the Bills JOHN W. JOHNSON
Recognizing that the hospital industry is the largest single granter of credit in the country, this credit expert offers a realistic approach to collection problems that will provide a businesslike income.....63

Preventive Credit Program Helps Patients Pay Bills MARILYN M. SLADE
A plan to prevent the bills from piling up.....64

Building Survey Reveals Addition Problems SHEPARD D. ROBINSON
Those who replied to a Modern Hospital survey of recent projects tell why their additions were built and discuss problems of building.....68

Good Planning Means Good Building ROUND TABLE
An authoritative panel discusses planning the elements, saving or discarding old buildings, and avoiding problems on the job.....71

Programming Is a Necessary First Step E. TODD WHEELER
A written program for the expanded plant provides the administrator with a new insight into the operations of the departments.....87

Checklists for Planning Departments
A point-by-point enumeration of things to consider in programming the surgery, the central service, the recovery room, and the emergency room.....90

1957 Modern Hospital of the Year
Grossmont Hospital, La Mesa, Calif., is honored.....94

They Have Such Awful Manners in Hospitals
Observing that the patient was there before the hospital was, one patient who has nothing but praise for his medical treatment asks for a bit more thoughtfulness and courtesy to make hospitalization tolerable.....95

Continued on next page ►

Editor, ROBERT M. CUNNINGHAM JR. *Assistant to the Editor,* SHEPARD D. ROBINSON
Associate Editors, MILDRED WHITCOMB, JANE BARTON *Assistant Editor,* ANN M. UNDERWOOD
Advertising Director, J. W. CANNON JR. *Chicago Advertising Offices:* 919 N. Michigan Ave., Chicago 11, Ill.
Eastern Office: 119 W. 40th St., New York 18, N.Y. *Cleveland Advertising Office:* 19030 Westlake Road, Cleveland 16, Ohio
Western States Advertising Representative: Bob Wettstein & Associates, Los Angeles, San Francisco

The Modern Hospital

Ask Doctors to Pass Along Comments

Patients tell doctors gripes they won't tell the administrator.

EDWARD R. PINCKNEY, M.D. 96

MEDICINE AND PHARMACY

How Laboratory Service Can Be Improved

A method of plotting averages of clinical specimens is proposed that will check laboratory mistakes before they become serious.

ROBERT G. HOFFMANN 102

FOOD AND FOOD SERVICE

Good Food Is Good Medicine for the Aged

A special effort must be made to consider the food likes and dislikes of the nursing home patient, two operators agree.

As told to JOAN ROCK 108

MAINTENANCE AND OPERATION

We Spent $2800 to Save $1800 per Year

By installing a capacitor, this hospital uses less current to do the same work and gets a lower rate on its electricity.

R. A. BRADBURN 116

HOUSEKEEPING

A Training Program for Housekeepers

Training is a continuous process for the housekeeper who wants to avoid spending her day "putting out fires." End of a series.

BARBARA D. MILLS 120

Good Housekeeping Reduces Infections

What the housekeeper can do about reservoirs of infection.

SALLY HEITMAN 54

REGULAR FEATURES

Reader Opinion	6	News Digest	132
Roving Reporter	8	Coming Events	163
Public Relations	12	Classified Advertising	173
Small Hospital Questions	47	What's New for Hospitals	189
Wire From Washington	48	Index of Advertisers	224
About People	100		
Menus for April	114		

Published monthly and copyright © 1958 by The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11, Ill., U.S.A. (Cable Address: Modital, Chicago.) Howard Barringer, president; Robert F. Marshall, executive vice president; Robert M. Cunningham Jr., vice president and editorial director; H. Judd Payne, vice president; J. W. Cannon Jr., assistant vice president; Stanley R. Clague, secretary; John P. McDermott, treasurer. Subscription price in U.S., U.S. Possessions and Canada, $4 a year and $6 for two years; elsewhere, $6 a year and $10 for two years. Single copies, $1. Member Audit Bureau of Circulations. Associated Business Publications. Entered as second-class matter, Oct. 1, 1918, at the Post Office at Chicago, Ill., under the Act of March 3, 1879. Printed in U.S.A.

"Friend . . . or Enema?"

Pardon our light touch . . . but

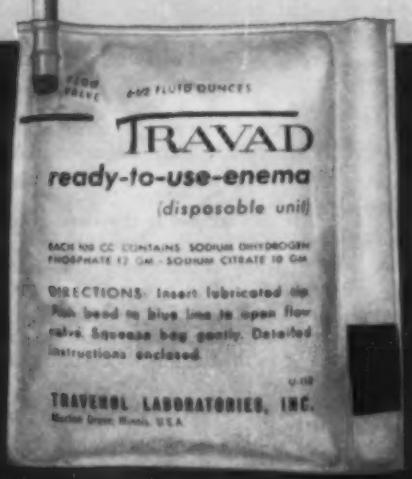
TRAVAD

does have the "light touch," because it's the only ready-to-use, disposable enema with the aesthetic *plus feature*—18″ of flexible tubing . . . and Travad costs no more.

Travad, thoroughly hospital tested by 3500 nurses and developed according to their "on-the-job-specifications" offers the following advantages:

- 18″ of flexible tubing for more aesthetic, convenient administration
- pre-lubricated tip in handy side pocket of unit
- nothing to assemble or clean up afterwards
- clear plastic bag to see and regulate solution rate of flow
- can be given in a fraction of the time required for conventional enemas
- time-proved formula . . . each 100 cc. contains 12 Gm. sodium dihydrogen phosphate, 10 Gm. sodium citrate

But, see for yourself... **at our expense,** *the Advantages of* **Travad**



Fill out and mail the coupon today.

TRAVENOL LABORATORIES, INC.
MORTON GROVE, ILLINOIS

I would like to receive a complimentary trade package of TRAVAD

NAME.....

HOSPITAL.....

ADDRESS.....

CITY..... STATE.....

READER OPINION

Hospitals Do Pay for Blood

Sirs:

I want to compliment your writer on the article appearing in the December issue of The Modern Hospital entitled "Blood Replacement Plan Is Described." I think the writer has done a very commendable job with a rather difficult subject.

On the same page of the magazine I was impressed with one paragraph concerning the study showing that hospitals collect 40 per cent of all blood used in transfusions. In the article it states "It is interesting to note that neither of these two sources which together collect 79 per cent of the nation's blood for transfusion, pays the donor." It is true that the Red Cross collects blood without payment to the individual donating the blood. This is not true in hospitals. The hospital may not pay the donor per se but the amount of money is refunded to the given patient. In essence, it doesn't make much difference where the money goes as long as it goes for the blood, whether to the donor or to the patient.

I do think it is important to point out that hospitals, whether they pay the donor or recipient, are still paying for the blood itself. This fee incidentally varies anywhere from $7.50 to $35 across the nation.

Coye C. Mason, M.D.
Clinical Laboratory
Chicago

Cost of Processing Syringes

Sirs:

The members of our nursing class have done time and motion studies on the processing of syringes. We have found our cost per syringe to be much greater than that stated by Arthur Young & Co., in the September issue of The Modern Hospital. In our study we found that a minimum of three minutes was required per syringe in processing. In view of this fact, our cost of labor alone for sterilization was $0.05 each.

Will you please let us know the minimum length of time you arrived at and the methods of processing used?

Rachel M. Pue
Medical College of Georgia
Augusta, Ga.

Ed. Note: A query to our consultant on sterilizing procedures elicited the following reply:

"There was no exact time noted for an individual syringe processing. However, syringe labor costs were arrived at by dividing the number of syringes processed by the time spent and the results shown as a cost figure in cents.

"Since the variation in labor costs would not be a large variant, it could be assumed that one of two things is taking place:

"First, the methods used were far slower than necessary and can be corrected by interchange of information with other hospitals in the area, particularly those which are supposed to have good central supply operations, or

"Second, the staff of the hospital is insisting upon an elaborate technic which they feel will assure absolute sterility of the items.

"If this second is the case, there is little that can be done to cut costs. We have encountered this second type of cost in a number of institutions and have knowledge of one where the actual injection cost is felt to be in the neighborhood of 30 cents, most of this due to the elaborate precautions insisted upon by the chief of staff to assure sterility."

NOW! pick the tray "look" you prefer...

Mealpack Systems now offer these attractive choices

MODEL 11-MG CONTAINER

Vacuum sealed entree protection for up to 2 hours. No gasket required in bottom half. New stainless steel elegance and durability.

MODEL LP TYPE PYREX DISH

No partitions. Now supplements Model TUF compartmented Dish to attractively serve breakfasts like pancakes, sausages, special dish, etc.

OPTIONAL CHINA DISHES

Attractive new china dishes. Models C-FG (forest green border) and C-PW (plain white), available for use in Models 11-MP and 11 Containers.

HOT-PAK TRAY SERVERS

Keep entrees HOT for one hour. Use any entree dish up to 9½" dia. Three simple elements: Attractive plastic Tray and Dome Cover; efficient Heat Battery.

PLUS... ...matchless controls over all kitchen work flow!

Only Mealpack's know-how and products bring you these cost and time savers

STORAGE AND HANDLING CARTS

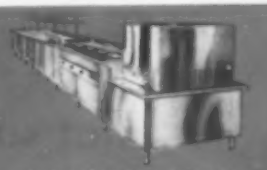
Mealpack Systems provide compact, efficient portable units for protecting Containers, Dishes, also Hot-Pak Tray Server units, throughout washing, storage and kitchen handling procedures.

INFRA-RED DISH HEATERS

Electric and gas types for use with Mealpack Containers or Hot-Pak Tray Servers ensure accurate, uniform Dish preheating; fast handling; adequate heathold without overcooking.

COMBINED COOK'S AND TRAY SETUP TABLE

These efficient pass-along type "work islands" replace several separate kitchen items otherwise required. Saves initial costs, space, steps and personnel.



MOTORIZED-BELT TABLES

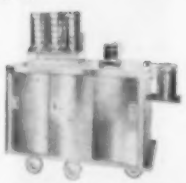
Custom-engineered to every need. Compactly centralizes all operations for tray setting – including special, general and selected menus—under rigid main kitchen supervision up to 1,000 trays per hour.

PLUS... ...trouble-free Tray Carts best suiting your needs!

The right tray carts stop on-floor mistakes; cost less; save space.

MODEL 20-SDT TRAY CART

This popular original "floor pantry on wheels" is now one of many Mealpack tray transport designs . . . Each custom-fitted to your exact needs and objectives.



MODEL 21-SDT TRAY CART

Side-door opening type, capacity 21 trays. View shows optional insulated Beverage Dispensers (3), Food Jars (2), and 2-slice Toaster.

MODEL 28-SDE TRAY CART

End-door opening type, capacity 28 trays. View shows handy, insulated Cold Compartment with "Freezishelves" for protecting cold foods at serving points. Model 28-SDS has side-opening doors.

REDI-SERV TRAY CART

Capacity 21 trays. Requires *no tray completion work* on floors! Can Serve 63 trays in 45 minutes by making three trips!

ALL wrapped up with *undivided responsibility* for the end results and savings you expect; and *assured* by Mealpack's exclusive installation training of all Dietary personnel covering all phases of correct care and use of *your* "custom-engineered" Mealpack System.

REMEMBER:

the BIG things you need cost LESS from

mealpack

T. M. REG. U. S. PAT. OFF.

U. S. AND FOREIGN PATENTS ISSUED AND PENDING.

MEALPACK CORPORATION, EVANSTON, ILLINOIS

IN CANADA: ARNETT CO., LTD., WINNIPEG. LICENSED MANUFACTURERS AND DISTRIBUTORS.

MEALPACK

ROVING REPORTER

Hemingway's Hideaway?

Unusual or famous patients have attracted attention before at Baptist Hospital, Pensacola, Fla., but Alex Alebey (Alibi?) tops the list. A recent issue of *Floriscope*, monthly publication of the hospital, tells the story of Mr. Alebey.

"Upon arrival, he looked different . . . and he performed to match! Advanced in years, yet with tremendous vitality and wit to match, he paraded the halls in a tattered robe, rolling verses and phrases off his tongue; all the while he snapped impishly at personnel, making everyone realize that he was—different. Who was he?"

"Ernest Hemingway," said Dr. Oscar Martinez. Dr. Martinez had seen the writer before, and was sure of the patient's identity. The patient's knowledge of Spanish and his wealth of information on bull fights and the Spanish revolution seemed to add up.

Other doctors dropped in to visit with the mystery man, and learned many details but few facts. Said the hospital's office: "We've never had a patient about whom we knew less."

Alex Alebey claimed to be a resident of Havana, in the States to buy the hull of a boat for remodeling. He talked frequently on many subjects, including tales of the Mau-Maus of the Kenya country. His discussion of fine foods ranged from birds' nest soup to bumble bee wings under glass. But—no word as to his real identity.

Rumors continued to spread. Insurance papers, thought one hospital detective, would surely establish the truth. Mr. Alebey paid in cash! Perhaps newspapermen could be admitted to get a story—they weren't allowed in the room. And so it went.

Before he left, however, the patient created "one great work," which the *Floriscope* printed. It is entitled, "Ode to an EKG."

"You little box, imprisoning a scribing imp inside.
Metering life's impulses of the vital pump you see
With tentacles, entwining limbs, that can so well decide
The COR's malfunctions: you are so perfect, but for the KAY in EKG.
You see, In Germany KARDIOGRAM is spelled and starts with a KAY
The box was born there and retains its cognomen in the Germanic way
Far be it from me to criticize this clever evaluator
But if here in U.S.A. we spelled it with a 'C,'
T'would be much better!"
Was Alex Alebey Ernest Hemingway?

Rehabilitation Is the Goal

A 2100 bed, $22 million hospital for the indigent sick, eight miles from downtown Pittsburgh, has been designed to make patients want to get out of bed.

The Allegheny County Institution District Hospital, otherwise known as the John J. Kane Hospital, was dedicated last month to replace the former Woodville Institution for the care of aged patients.

The new hospital, completely modern in design, comprises an eight-story main building, two convalescent wings of three stories each, two rows of ambulatory dormitories surrounding a park-like area, an auditorium, interdenominational church, nurses' home, and eight doctors' residences.

More than 6500 windows overlook the beautifully landscaped grounds of

When Methodist Hospital, Peoria, Illinois, decided to get a second Caterpillar Electric Set for emergency power to handle expanding facilities, installation, as usual, was simple and quick. These photos show the D318 loaded on a heavy-duty truck at the Caterpillar Tractor Co.'s Engine Division . . . craned out of the truck at the hospital . . . lowered opposite the boiler room entrance . . . guided through the aperture easy as you please . . . slid into the boiler room . . . and eased off at its final resting place, ready to take over in seconds should utility power fail. Cat power units can be counted on when needed.

HOSPITAL EXPANDS—BUYS SECOND EMERGENCY UNIT—INSTALLATION EASY AS ABC!

As Methodist Hospital grew with the community, it decided to get another CAT emergency power unit to safeguard patients—this one, a D318, to assure power for the boiler room so heat for the hospital would not be cut off in the event of commercial power failure.

"I think Caterpillar has the very best diesel on the market, and the generator is as good as any on the market," says Edwin H. Peyer, Chief Engineer for the Hospital. "These units are very dependable, have very good automatic control, very stable voltage regulation."

Hospitals, *large* and *small*, are protecting their patients against the serious consequences of commercial power failure by installing dependable Cat emergency power. And hospital administrators are finding the cost comparatively low and installation fast and simple. Cat units can be depended on to start up automatically within seconds, and the safe storage of low-grade diesel oil is a plus factor to be seriously considered.

Phone your nearby Caterpillar Dealer Installation Engineer for cost estimates and expert advice.

Engine Division, Caterpillar Tractor Co., Peoria, Illinois, U. S. A.

ENGINE POWER
BY CATERPILLAR

Dept. MH3, Engine Division
CATERPILLAR TRACTOR CO., Peoria, Illinois, U. S. A.

I am interested in Caterpillar Diesel Electric Sets for emergency power.

- ☐ Have your dealer call for an appointment.
- ☐ I would like detailed literature concerning the use of these units in hospitals.
- ☐ I am interested in learning how to obtain federal matching funds for the purchase and installation of a Cat Electric Set for hospital emergency power.

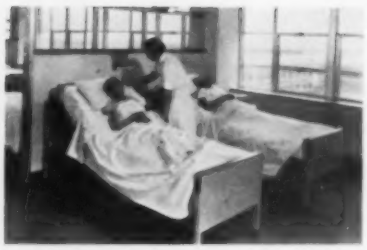
Name _____

Hospital _____

Address _____

City _____ *Zone* ____ *State* _____

Aluminum and glass are the featured construction materials of new county hospital. Main building is at right; pyramid shaped structure is the church.



Ward beds are separated by partitions into groups of four. Sixty-seven registered nurses, 500 attendants will work at rehabilitation hospital.

the hospital, planted with trees, shrubs and flowers to boost patients' morale and encourage their interest in the surroundings.

Although the hospital is not exclusively for aged patients, officials believe that more than 70 per cent of its patients will be medically indigent persons over 65.

"The whole purpose of this hospital," explains Dr. Gerard P. Hammill, director, "is to get away from the old institutional concept in which the patient became 'a prisoner of his bed,' staying in it because there was no other place to go.

"Our new hospital is planned to make the patient *want* to get up, to make him feel it is worth while to achieve even a few feeble steps; and to lure him into seeking better health by making life interesting within the hospital. Finally, through enlivening surroundings we seek to strengthen his will power to effect a cure."

The acutely ill will be housed on the upper floors of the hospital, near surgical facilities. Convalescents will be on the second and third floors, with access to the church and auditorium. Ambulatory patients will live in split-level infirmaries opening onto planted courts. More than 1300 patients will be accommodated on ground-floor level, and thus will be able to move about freely without using stairs.

Among the unusual architectural facilities are the church and auditorium. The church is triangular in shape, faced with green mosaic tile. The roof is copper, abutted by slanting multicolored windows. The altar, also a pyramid shape, has a revolving face to permit display of the religious symbol of each faith.

The auditorium, 100 feet in diameter, is a hemisphere of aluminum plates, and seats 750 persons. One balcony, empty of seats, can be used by patients in wheel chairs and beds.

A complete rehabilitation program has been planned, in keeping with the hospital's goal of restoring aged patients to better health, and family, rather than institution, living.

Frequently, the first step in this rehabilitation process is to teach the patient how to sit up in bed unassisted. Later, he may learn to control a wheel chair and work with exercise apparatus to relearn use of his limbs. When a patient cannot entirely master self-help, classes may be set up to teach his family how to help him when he returns home.

A system of foster homes also is an aim of the hospital. Such homes could provide a normal life for patients able to leave the hospital but without relatives to take them in.

In addition to music and movies, the recreation therapy program will include participation in hobbies and arts and crafts. Clubs, discussion and choral groups, dramatics, gardening and use of the hospital library will be encouraged; educational programs will be offered.

Within the wards, 21 colors have been used. No ward on the same floor is the same color, so that aged or confused patients may be able to remember their living place by color alone. Furniture color will vary from room to room to avoid monotony.

To boost the morale of ambulatory patients, twill suits for men and bright print dresses for women will be provided; these will be carefully washed and pressed in the hospital's laundry, which has a capacity of 15,000 pounds per day.

Other facilities to aid patients are the medical social service, discharge planning, recreation, canteen, and a beauty and barber shop.

Clinical services will include major and minor surgery, diagnostic and therapeutic x-ray, clinical and pathological laboratories, and a pharmacy, plus various medical specialties. Thirteen doctors will serve on a full-time basis, and 15 others will be on call if needed, in addition to 20 consultants. There will be 67 registered nurses and 500 trained hospital attendants.

The buildings were designed by Button and McLean, and Mitchell and Ritchey, architectural firms of Pittsburgh.

POSITIVE DECONTAMINATION

• BEDPANS • URINALS

American cyclo-flush

Automatic, positive decontamination with the American Cyclo-flush protects patients and hospital personnel by limiting the carrying of communicable diseases via bedpans and urinals. The electromatic Cyclo-flush thoroughly washes all inside and outside surfaces of pan and chamber with a 25-second cycle of air-entrained cold water — then instantly, steam at 212° F. saturates interior of chamber for 30 seconds . . . killing communicable disease organisms. End result is a sparkling clean utensil ready for use in *any* department or ward.

Amsco Cyclo-flush is finished in vitreous enamel, assuring protection against residual stain and corrosion. Flushing of chamber and pan is complete and thorough.

Time-saving feature of the Amsco Cyclo-flush is important additional benefit. Upon insertion of pan into Cyclo-flush chamber, nurse is free to leave unit and do other work . . . while the utensil is being cleaned AUTOMATICALLY.

Offices in 14 Principal Cities

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Be Sure You Know Your Audience When You Write That Annual Report

BY GORDON DAVIS

Gordon Davis

EARLIER than the crocus blooms the annual report, but its mission in life is not quite so uncomplicated.

Some annual reports, indeed, seem designed chiefly to delight statisticians. Others sound the roll with the omniscience of the Angel Gabriel. They are miniature social registers, in effect.

In general and in particular, we tend to commend both statistics and personalities. The latter are human, and the former bring order to human life.

But if you must disseminate such facts, have a care to conceal their bony nakedness under a reasonably presentable cloak of showmanship. Long columns of figures, names or departmental minutiae fail wholly to beguile the average reader. The annual report most likely to be cherished is one that has narrative value, that compels new appreciation of its sponsor.

We like the report that we put down with a sense of increased understanding.

We like illustrations that show people in natural action.

We like good typography or, if this is too expensive, at least a mimeograph job that is legible throughout.

To be sure, it's easier to list likes than to serve them. Few written messages call for more planning and more effort per word than a good annual report.

The first step toward the attainment of such a report is a discerning alignment of audiences. A report intended solely for a board of trustees is one thing; a report for a medical staff may be another; a report for public consumption can be still a third. The same report is not suitable for diverse audiences unless it contains dominant information of common interest to all.

Step two toward the good report is organization; step three is writing. Steps four and so on progress through layout, illustration, typography and reproduction.

We have seen annual reports of astonishing beauty that were no less astonishingly shallow. We have seen unpretentious, mimeographed reports that had the impact of a pile-driver. Each year's crop is fascinating in its diversity, its ingenuity, its pedestrianism, its extravagance, its humility. Time spent in examining these products from your own field and from fields other than your own can be highly rewarding.

The production of the annual report is hard work. It is too infrequent to be organized into a routine. It has the fundamental merit of forcing periodic evaluation and contributing new perspective. It can also be a basic instrument of good public relations.

When you tackle your report, be sure that you know in detail what you want it to do for you and how it can best serve this purpose. In many ways it will reveal more about the work of your hospital than anything else you do.

garments made of Indian Head® all-purpose cotton last longer, look better longer, too!

PRINCETON HOSPITAL
PRINCETON, N. J.

JOHN W. KAUFFMAN, Administrator

January 23, 1958

Indian Head Mills
1407 Broadway
New York 18, New York

Gentlemen:

We have kept an accurate check of the serviceability and appearance of the garments made of Indian Head all-purpose cotton used in our Hospital and have found that these garments are long-lasting and keep their good appearance for a long time. This long "life" of the garments made with your product is, of course, important to an organization such as ours where we must effect every economy and at the same time provide the most in care and service.

Very truly yours,
John W. Kauffman
John W. Kauffman
Administrator

Check list of hospital linen uses for which Indian Head brand all-purpose cotton is ideal

DOCTORS	NURSES
☐ O.R. Suits	☐ O.R. Scrub Dresses
☐ Gowns	☐ Gowns
☐ Caps	☐ Caps

SHEETS:
☐ Laparotomy ☐ Eye
☐ Gyn ☐ Window
☐ Perineal ☐ Ear
☐ O. B. ☐ Circumcision

COVERS:
☐ Tray ☐ Table
☐ Mayo ☐ Instrument Wrappers
☐ O.R. and Sterile Packs

UNIFORMS:
☐ Maids ☐ Waitresses
☐ Aids and Orderlies
☐ Porters
☐ Volunteer and Auxiliary
☐ Chefs' and Kitchen Help

MISCELLANEOUS:
☐ Cubicle Curtains
☐ Drapes
☐ Table Cloths and Napkins
☐ Doctors' Office and Lab Coats
☐ X-Ray and Examining Gowns

For the guaranteed assurance of long-lasting serviceability and good-looks, hospital garments made of Indian Head brand all-purpose cotton cannot be matched. This fabric has a crisp, linen-like texture particularly suited to institutional use. Available in a wide range of vat-dyed, permanent-finish, pre-shrunk hospital colors. For the economy, serviceability and good looks that you want for your hospital, make sure that you ask your supplier for garments made of guaranteed* Indian Head brand all-purpose cotton.

AMERICAN INSTITUTE OF LAUNDERING CERTIFIED WASHABLE

Write to Hospital Service Department, Indian Head Mills, Inc., 1407 B'way, New York 18, N.Y. for swatch card of special hospital colors.

The Famous Indian Head Guarantee: *"If any article made principally of an Indian Head Brand Cotton fails to give proper service because of the fading or running of colors, or if the fabric shrinks more than 1%, we will make good the total cost of the article."

INDIAN HEAD® *all-purpose cotton*

a product of Indian Head Mills, Inc. Also makers of famous Pequot Sheets.

a floor cleaner that costs less than a Clarke

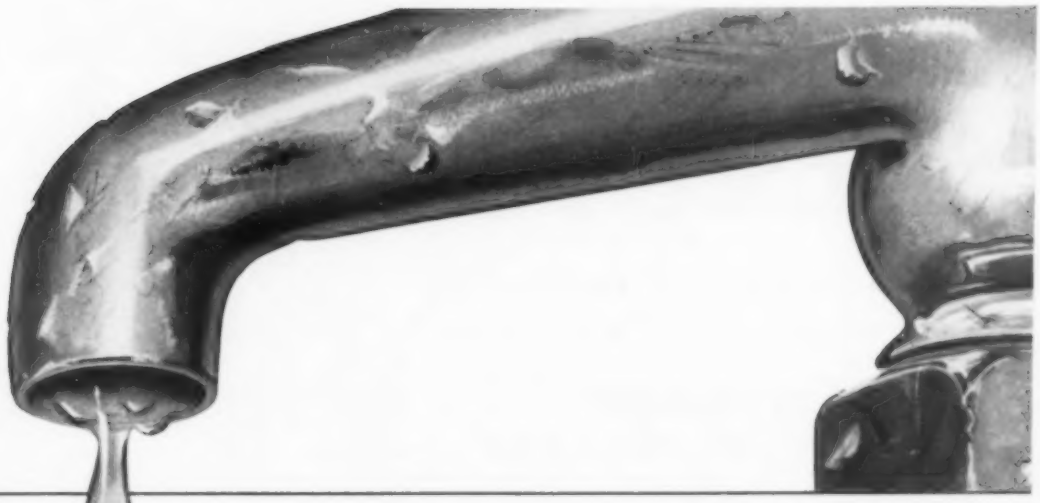
Yes, the initial cost of this mop and bucket is extremely low. But in the long run, the expense of mop cleaning becomes prohibitive. It costs 10 to 20 times as much as cleaning by machine, considering all the expensive manual labor involved — and doesn't do a complete job. That's why most people are cleaning by machine nowadays. And for really dependable performance they're choosing Clarke. The right size Clarke means lowest possible maintenance cost and sparkling, sanitary floors.

Whether you choose a Clarke floor maintainer, wet-dry vacuum cleaner (or both) or a Clarke-A-matic combination machine for large floor areas, you'll enjoy much more efficiency and economy than will ever be possible with a mop. Let your Clarke distributor show you.

Clarke **SANDING MACHINE COMPANY**

523 Clay Avenue, Muskegon, Michigan

Distributed in Canada: G. H. Wood & Co., Ltd., P.O. Box 34, Toronto 14, Ont.
Authorized Sales Representatives and Service Branches in Principal Cities.



How much of your budget drips down the drain?

More than you might think—unless you have Crane Dial-ese controls, designed to cut down water loss and water heating bills

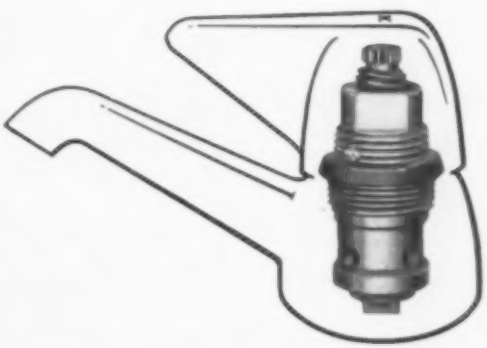
A drop of water a second, hour after hour, adds up to 2,300 gallons a year.

Multiply that by the number of faucets in your building, and you can see the incredible water waste that dripping can, and *does*, cause. And when it's *hot* water, there's a big fuel waste, too!

Crane Dial-ese controls are designed to stop this constant waste. For one thing, a Dial-ese control shuts off easier and all the way because it closes *with* the water pressure—not against it.

Dial-ese is designed to last longer, too. Stem threads are permanently lubricated at the factory —and sealed *inside* where water can't touch them. All working parts are in a single, simple cartridge that screws into the faucet. *Replacement is quick and easy*—just take out the old, put in the new.

All Crane fixtures (and *only* Crane fixtures) feature Dial-ese controls. Why not ask your architect for more details before you build or remodel?



CRANE DIAL-ESE PERMITS STANDARDIZATION. The same renewable unit fits all Dial-ese controls... lavatories, bathtubs, showers, sinks and laundry tubs.

CRANE THE PREFERRED PLUMBING

CRANE CO. 836 S. Michigan Ave., Chicago 5 • VALVES • FITTINGS • PIPE • PLUMBING • KITCHENS • HEATING • AIR CONDITIONING

GO ELECTRIC

for Cooler, Cleaner, More Efficient and *More Economical* Food Service!

HEAVY-DUTY VERSATILITY! TOASTMASTER 54" COMBINATION OVENS

HEAVY-DUTY ovens with exact heat control . . . *electrically!* Bake, roast to perfection—cut meat shrinkage as much as 15%! Full two-pan size sectional bake and roast units stack one above the other—offer "Build-On" versatility. Bake section (top) has smooth one-piece core plate deck, eliminates hot and cold spots. Roast sections (bottom units) have pebble steel deck to prevent burning. Heavy insulation in each unit provides maximum heat retention—greater economy—and gives the coolest, cleanest cooking possible! Also a complete selection of 36" (1-pan size) all-purpose ovens for baking and roasting.

H541B2R

HR36D

SPACE-SAVING POWERHOUSE! "SQUARE-YARD" RANGE

Meets every cooking need . . . *electrically*! Compact all-purpose HEAVY-DUTY range is exactly 36" square—designed for flush-wall installation—provides almost 6 sq. ft. of cooking surface *plus* a big standard one-pan size all-purpose oven. 3 top sections, each thermostatically controlled, with infinite heat settings (250° to 850°) for griddling, stockpots, all top-of-range cooking. Extra-thick oven insulation for cooler, more economical baking and roasting. Toastmaster "SQUARE-YARD" Ranges are available in a complete selection of top combinations to meet any specialized cooking requirement.

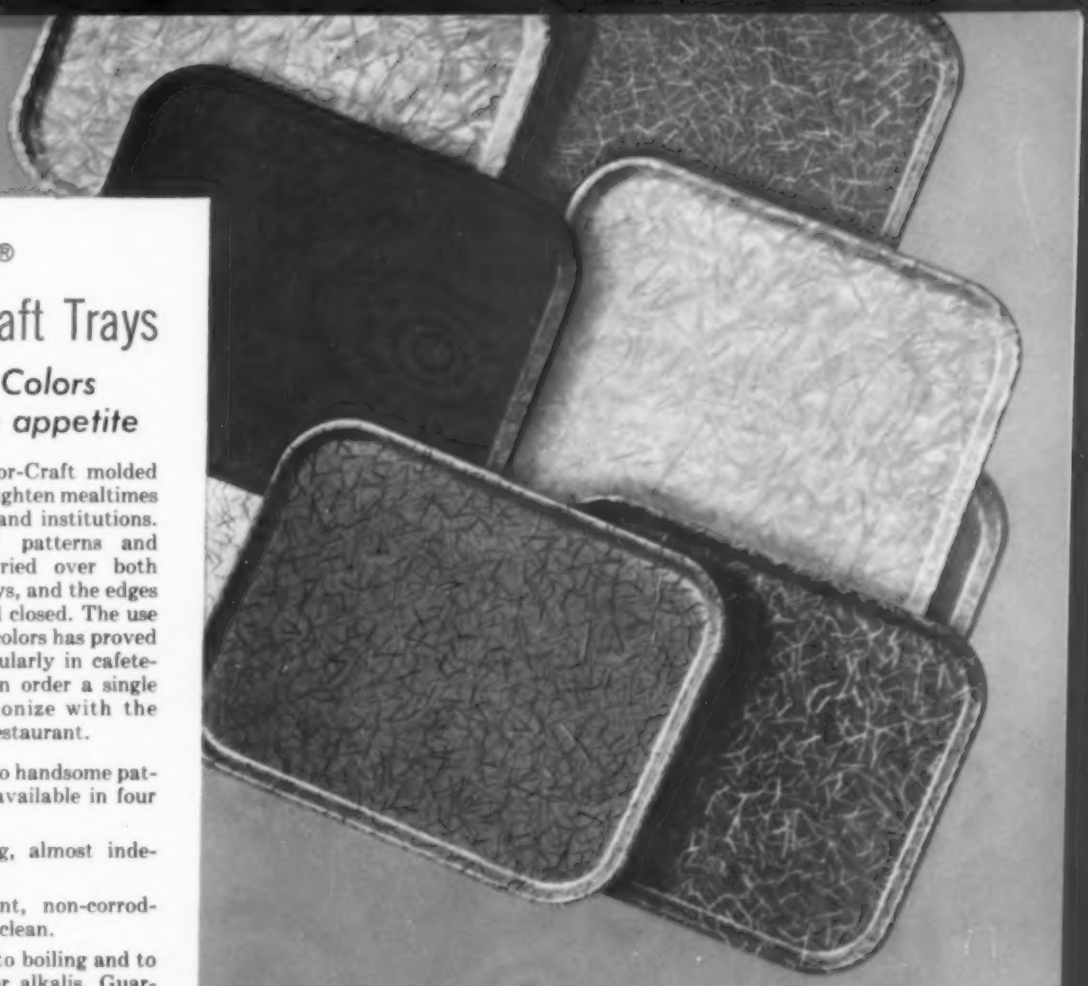
The Complete Line of Electric Cooking Equipment

TOASTMASTER

McGRAW EDISON

"TOASTMASTER" is a registered trademark of McGraw-Edison Company, Elgin, Illinois

TOASTERS · BUN TOASTERS · SANDWICH GRILLS · BROILERS · FRY KETTLES · GRIDDLES · GRILLS
HOT-FOOD SERVERS · HOT PLATES · OVENS · RANGES · WAFFLE BAKERS · FOOD WARMERS



KYS-ITE® Color-Craft Trays

. . . Gay Colors whet the appetite

KYS-ITE Color-Craft molded plastic trays brighten mealtimes in restaurants and institutions. The beautiful patterns and colors are carried over both sides of the trays, and the edges are smooth and closed. The use of a variety of colors has proved popular, particularly in cafeterias, or you can order a single color to harmonize with the décor of your restaurant.

- Choice of two handsome patterns, each available in four colors.
- Extra strong, almost indestructible.
- Stain-resistant, non-corroding, easy to clean.
- Impervious to boiling and to mild acids or alkalis. Guaranteed not to warp.
- Lightweight and quiet in use.

a complete line of trays to fill every need

REGULAR KYS-ITE® SERVING TRAYS
for durability and economy. 10 sizes available in red, brown and rust.

KYS-ITE® CORK-SURFACED TRAYS
for non-skid, safety service. 5 sizes available in red and brown.

Be Wise-Buy

KEYES MOLDED PRODUCTS

MAIL THIS COUPON

Keyes Fibre Company, Waterville, Maine

Please send further information on KYS-ITE, KYS-ITE Cork-Surfaced and KYS-ITE Color-Craft Trays.

NAME .....

NAME OF FIRM .....

ADDRESS .....

.....

4 PIONEER Rollprufs® Cover All Surgical Requirements

Tissue-thin White Latex with Flat Color Banded Beadless Wrists and easy-to-sort Multi-Size Markings in color.
RP-158

Non-slip textured area on fingers and palm of Brown Latex with Flat Color Banded Beadless Wrists.
RP-169R

Tissue-thin Color Banded Brown Latex with Flat Beadless Wrists and easy-to-sort Multi-Size Markings in color.
RP-168

Green Neoprene with Flat Banded Beadless Wrists for those allergic to natural latex surgical gloves.
75 LW

Color Identified to Cut Glove Sorting Time

Compounded to Withstand 10 to 20 Sterilizations

Quality-Made and Individually Inspected

the PIONEER Rubber Company
350 Tiffin Road, Willard, Ohio

Pioneers in Surgical Hand Protection for over 35 Years

Ident-A-Band®

. . . comfortable, positive, on-patient identification
Best . . . because it's sealed — *permanently sealed*

And you can readily see why the seal is important . . . why only a strong, permanently fastened seal will do. *Unless you are positive that the seal is completely reliable* you cannot be sure that the patient is correctly identified.

Only Hollister Ident-A-Band has this tamper-proof *permanent* seal. In addition, the hospital name and location printed on each band associates this "emblem of protection" with the hospital that provides it. It is worn home — often kept as a souvenir. Soft, safe, comfortable Ident-A-Band provides this important community GoodWill benefit.

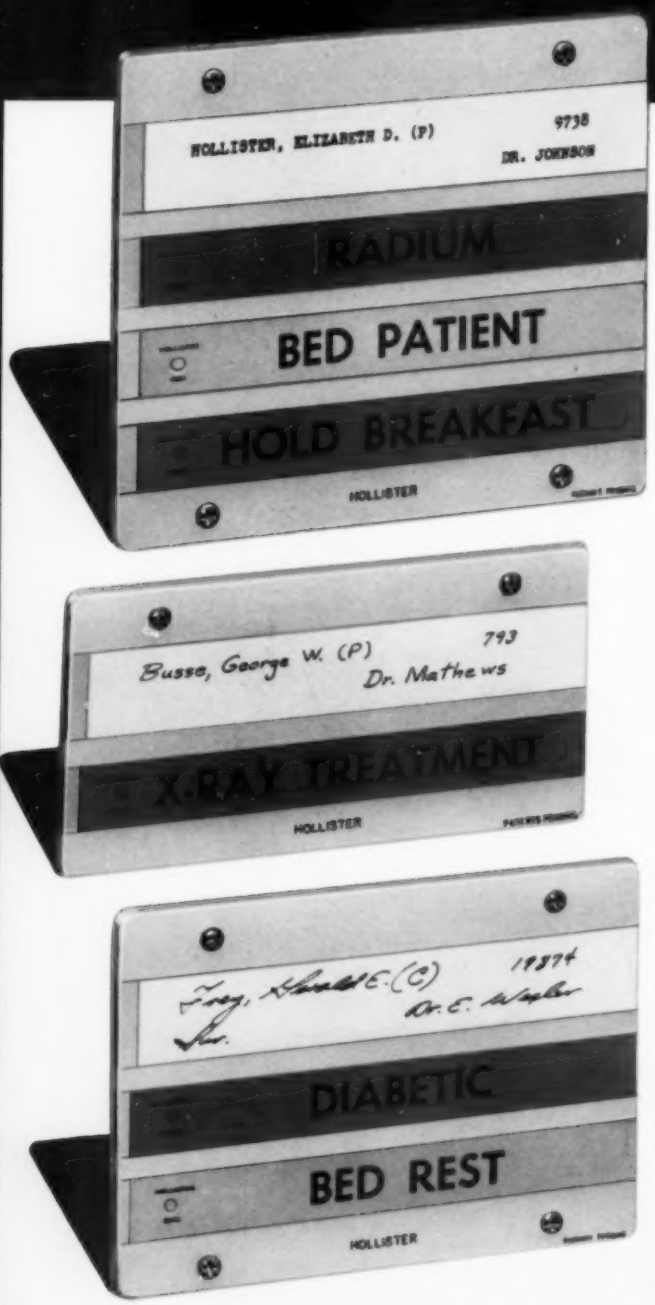
Ident-A-Band is the only method of on-patient identification proved efficient, reliable, convenient through actual use on millions of patients during the last five years. You can adopt or extend your system of Ident-A-Band protection with complete assurance that this comfortable, lightweight but strong band, *permanently sealed* will be welcomed by patients, nurses and doctors.

For FREE Ident-A-Band samples and complete information, write . . . . .

HOLLISTER®

FRANKLIN C. HOLLISTER COMPANY
833 NORTH ORLEANS ST., CHICAGO 10, ILL.

Beautiful Bed Signs by HOLLISTER®



A simple, efficient reminder system that meets every need of the modern hospital

The Hollister Bed Sign reminder system grew out of a long-felt need. Makeshift reminders written on scraps of paper didn't provide the degree of safety and efficiency today's hospital practice requires. Scribbled notes are hard to read, they may not be seen at all, they may be brushed away and they are unsightly. The Hollister reminder system overcomes these problems in a way that enhances the appearance of the room, encourages efficiency and provides the greatest possible convenience.

Hollister reminder cards are colorful and easy to read . . .

Hollister Bed Signs show reminders and instructions at a glance. Boldly printed, colored reminder cards — easily read from across a large room — slide smoothly into clear Plexiglas.* They stay in place, shielded from accidentally being brushed off or blown away.

Nurses, doctors, administrators welcome the efficiency and beauty

A quick glance at the Hollister Bed Sign — permanently attached to the bed — shows doctors, nurses and attendants the patient's name and special instructions. See for yourself how these signs create a most favorable impression by replacing makeshift notes and at the same time increase the efficiency of the hospital. Only $3.50 brings you a Hollister Bed Sign Demonstration Kit including one 4-slot bed sign and 15 sample reminders.

Plexiglas is a trade mark of Rohm & Haas Company, Philadelphia

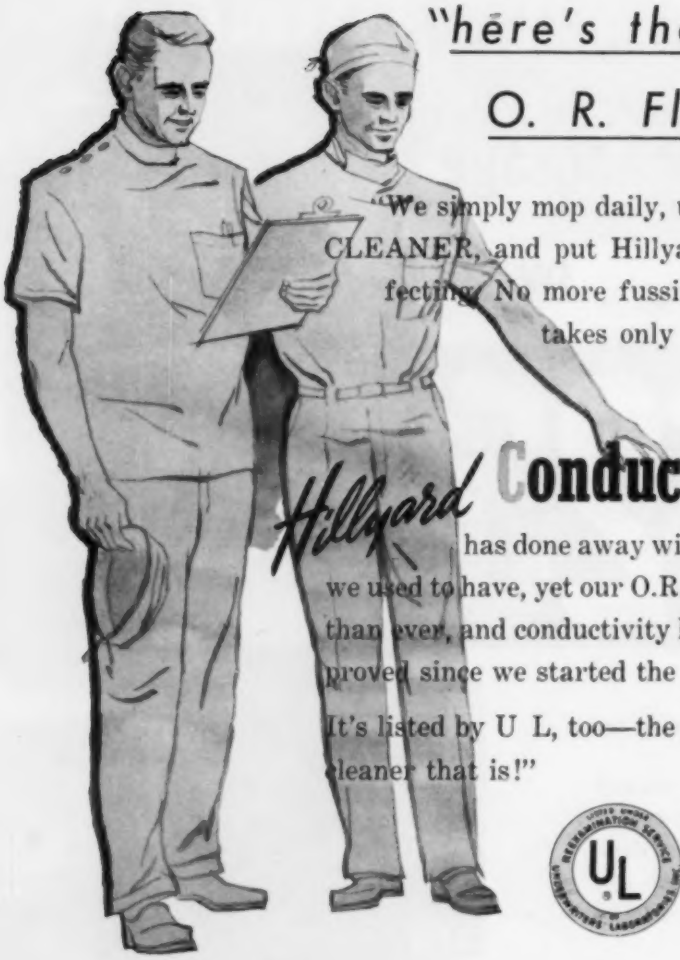
Bed Signs Can be Beautiful

Send for your copy of the colorful new 16-page book, *Beautiful Bed Signs*, that pictures and describes this modern reminder system. Yours FREE for the asking, write—

FRANKLIN C. HOLLISTER CO., 833 N. Orleans St., Chicago 10, Ill.

head anesthetist and

"here's the answer to our O. R. Floor problem!"



"We simply mop daily, using Hillyard CONDUCTIVE FLOOR CLEANER, and put Hillyard H-101 in the rinse water for disinfecting. No more fussing with conductive wax! Maintenance takes only a few minutes a day.

Hillyard Conductive Floor Cleaner

has done away with half the work we used to have, yet our O.R. floor is cleaner than ever, and conductivity has actually improved since we started the new treatment.

It's listed by U L, too—the only conductive cleaner that is!"

UL Relating to Hazardous Locations

There's Nothing Else Like
Hillyard CONDUCTIVE FLOOR CLEANER

✓ Fully meets requirements of NFPA Code No. 56, and is the ONLY floor cleaner to carry this UL listing.

✓ Dirt-removing capacity was tested, using radioactive isotopes, at nationally known independent testing laboratory. Report? — "99.2% grime removal"!

NON-DAMAGING

to any type conductive flooring. Recommended by leading flooring manufacturers to keep their floors conductive after installation.

ASK YOUR HILLYARD "MAINTAINEER®"

about a complete Hospital Floor Care Plan. Wards — corridors — reception and waiting rooms — diet kitchens — storage rooms — toilets — the Hospital has a number of *different* floors, each of which calls for a *different* treatment and maintenance program with specialized products to meet hospital requirements quickly and easily.

The Maintaineer will survey your floors — recommend treatments tailored to the flooring composition, location, kind and intensity of traffic — and train your housekeeping staff in the most effective ways to apply treatments selected.

He can often show you streamlined methods which eliminate whole treatment steps, take the drudgery out of floor care, help you save maintenance dollars and stay well within your maintenance budget.

His job has only begun when you sign the order

surgical supervisor agree...

ASK FOR HILLYARD AIA NUMBERED FILES

containing detailed product information, specifications, and step-by-step application instructions for each type floor in your Hospital.

MAIL COUPON TODAY

Serving the Nation's Hospitals for over 50 years . . . . The Hillyard Maintaineer's Consulting Service is without Charge or Obligation. He's *"On Your Staff, Not Your Payroll"*.

FLOOR HILLYARD TREATMENTS

ST. JOSEPH, MO.
PASSAIC, N. J.
SAN JOSE, CALIF.
Branches and Warehouse Stocks in Principal Cities

HILLYARD, St. Joseph, Mo. H-3

☐ Please send me a set of AIA numbered files covering treatment of all types of floors.

☐ Please have the Hillyard Maintaineer call and discuss a modern treatment plan for my floors that will save money in my maintenance budget.

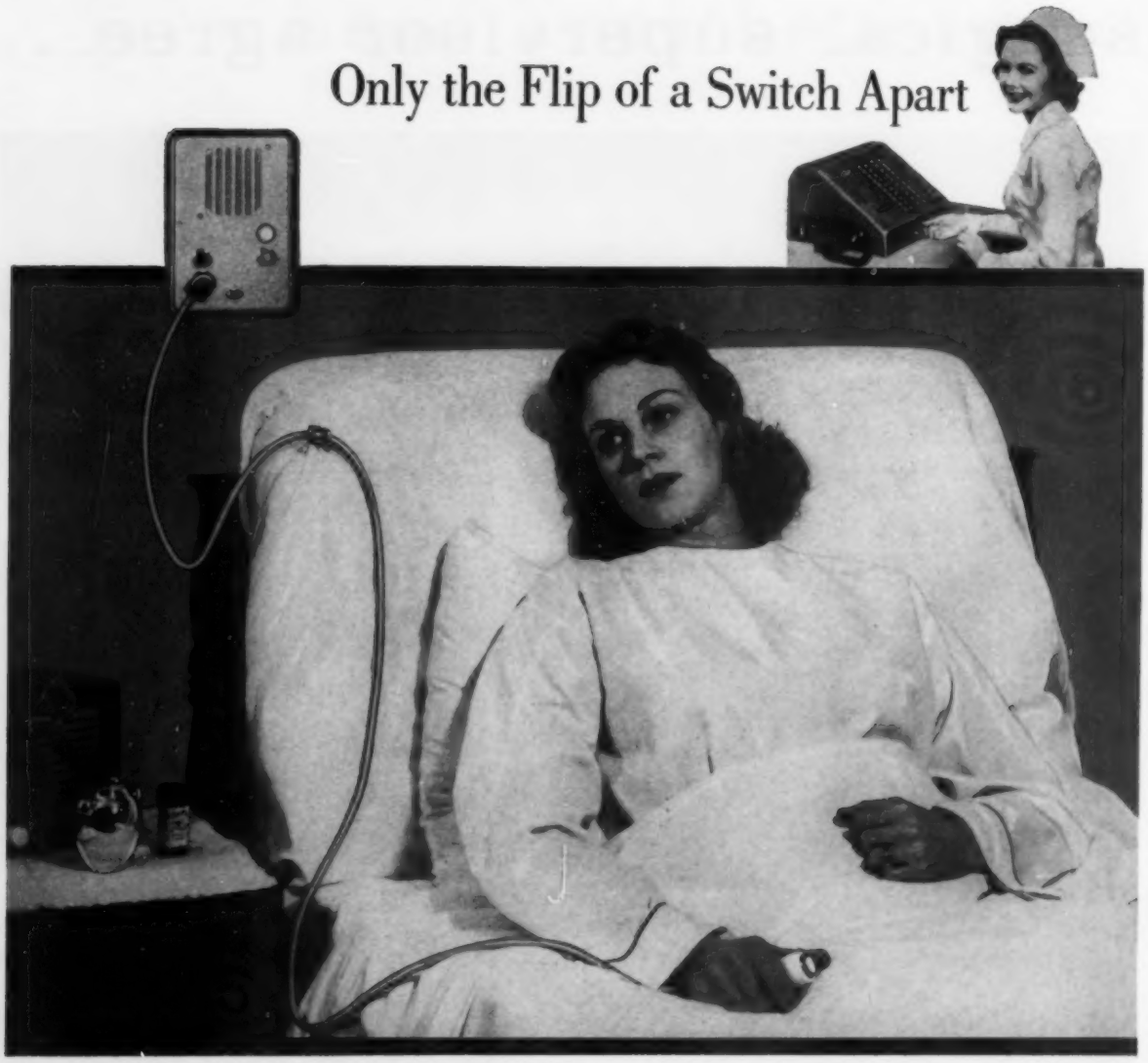
Name.....

Hospital.....

Address.....

City..... State.....

Only the Flip of a Switch Apart



"Vokalcall"*... audio-visual nurses' call systems providing two-way voice communication between patient and nurse... is fast becoming indispensable in modern hospital administration. Why? Because "Vokalcall" benefits the entire hospital. Patients recover faster when they feel secure... when they know that by the mere flip of a switch they can hear their nurse's voice and talk to her. Nurses benefit from a feeling of raised morale and accomplishment. They concentrate on direct bedside care, save footsteps, attend more patients. These good effects extend to other departments of the hospital. Greater overall accomplishment, reduced operating costs, and increased good will result.

"Vokalcall" systems are the products of constant research and development by the Auth Electric Company in signaling and communication systems for hospitals. For a copy of the most recent booklet "Vokalcall Audio-Visual Nurse's Call Systems" write to the address below.

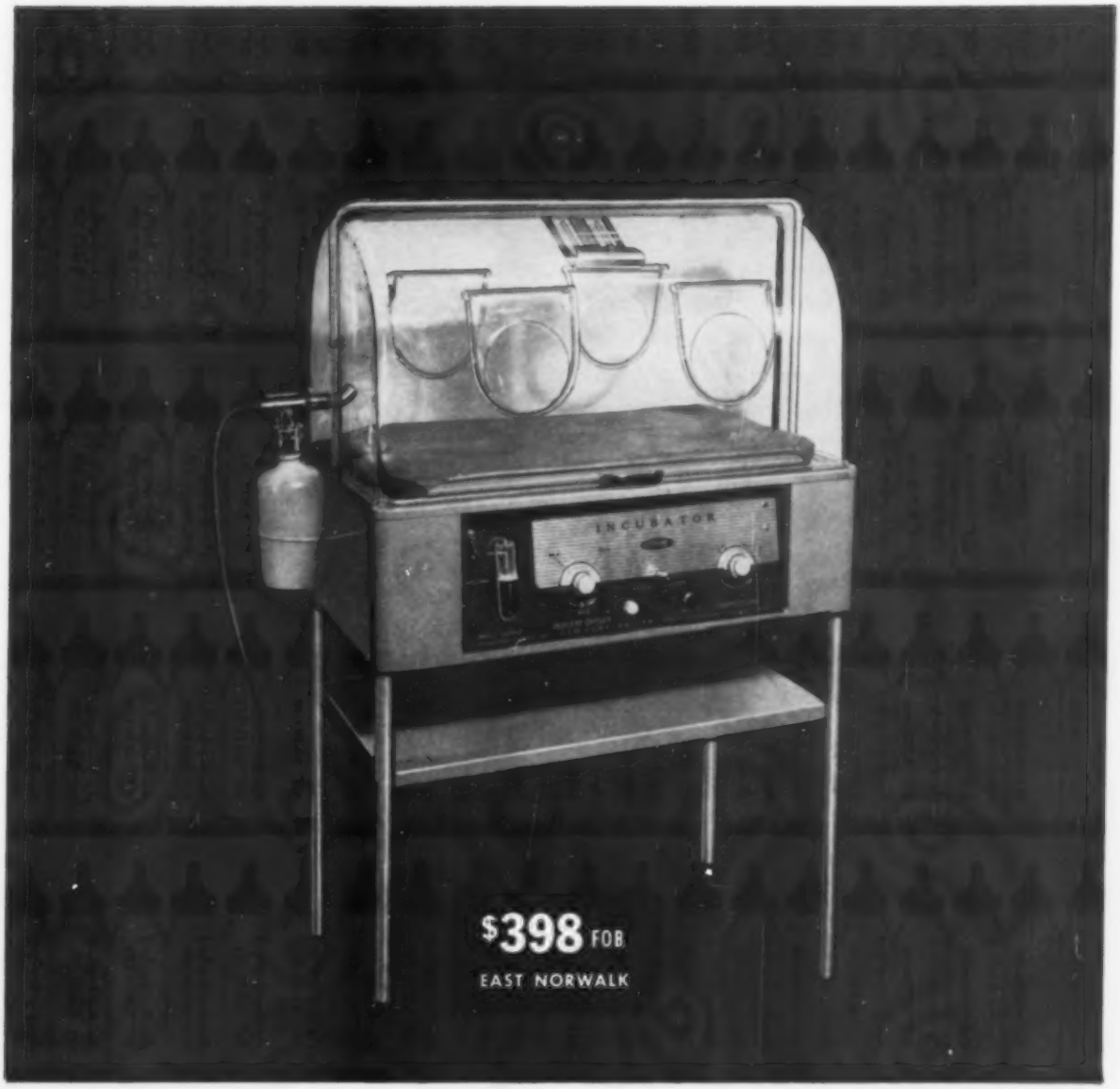
*Registered

Auth
SINCE 1892

Manufacturers of
ELECTRICAL SIGNALING, TIME AND COMMUNICATION SYSTEMS FOR HOSPITALS, SCHOOLS, HOUSING, INDUSTRY AND SHIPS

Auth Electric Company, Inc.

LONG ISLAND CITY 1, NEW YORK



BUY ONE OEM FORCED-CIRCULATION INCUBATOR AND SAVE THE COST OF 9500 NURSING BOTTLES

OEM Incubators . . . at $398 each . . . provide forced circulation for constant environment . . . simple, accurate temperature, humidity and oxygen controls . . . natural access for safe, easy infant handling.

Your OEM Incubator arrives completely assembled . . . ready to plug in and use. For service or maintenance, merely pull out the drawer-type power package.

Do your preemies (and your budget) a favor. Send for Catalog Supplement 10C today.

O·E·M CORPORATION EAST NORWALK, CONNECTICUT

A Shampaine Industry

THE *experience gained and specialized techniques developed in our nearly 40 years of service exclusively to hospitals have proved effective in building fund programs requiring modest sums, as well as many involving multi-million dollar goals. In the last 15 years, for example, we have directed 135 campaigns with objectives of less than $1,000,000, producing total subscriptions of $66,000,000. This represents 27 percent of the $242,000,000 contributed in our 219 hospital campaigns during this period.*

GEARED FOR LOCAL NEEDS

Among our clients in the last 12 months were eight hospitals seeking funds by public subscription ranging from $300,000 to $850,000. Each campaign was mapped to meet prevailing local conditions, and each resulted in a new record of response in relation to community resources. Almost 100 times in the same 15-year period, we have returned for second, third, and even fourth campaigns, as a result of the effectiveness of our time-tested methods. whether applied in programs to raise more—or less—than a million dollars.

ANNIE M. WARNER HOSPITAL
Gettysburg, Pennsylvania
Objective: $350,000
Subscribed: $373,000

CHRISTIAN WELFARE HOSPITAL
East St. Louis, Missouri
Objective: $850,000
Subscribed: $914,000

CLAREMONT GENERAL HOSPITAL
Claremont, New Hampshire
Objective: $350,000
Subscribed: $386,000

EXETER HOSPITAL
Exeter, New Hampshire
Objective: $600,000
Subscribed: $605,000

GOOD SAMARITAN HOSPITAL
Pottsville, Pennsylvania
Objective: $300,000
Subscribed: $421,000

MANCHESTER MEMORIAL HOSPITAL
Manchester, Connecticut
Objective: $850,000
Subscribed: $810,000

PORTER HOSPITAL
Middlebury, Vermont
Objective: $300,000
Subscribed: $331,000

THE HOSPITAL
Sidney, New York
Objective: $350,000
Subscribed: $358,000

FUND-RAISING AND PUBLIC RELATIONS COUNSEL TO HOSPITALS ONLY

Charter Member of American Association of Fund-Raising Counsel

137 NEWBURY STREET, BOSTON 16, MASS.

WILL, FOLSOM AND SMITH, INC.

25 WEST 43RD STREET, NEW YORK 36, N. Y.

BE SAFE

BE SURE

specify

1 **FACTORY GUARANTEED**

KNOW your operating room floors are RIGHT . . . the finished installation is tested and guaranteed BY THE FACTORY to meet all National Fire Protection Association and National Bureau of Fire Underwriters requirements for 5 full years!

2 **FACTORY CONTROLLED**

Every tile is individually tested for conductivity at the factory . . . installed ONLY under the supervision of factory-trained personnel.

3 **NO DISRUPTIONS**

CONDUCTILE can be installed without interfering with your surgical schedule . . . overnight, in most cases . . . with minimum muss and fuss.

CONDUCTILE CONDUCTIVE VINYL FLOORING

. . . made only by
VINYL PLASTICS INC.

SHEBOYGAN, WISCONSIN

MH38

PLEASE SEND FULL STORY NOW!

We would like full details on CONDUCTILE conductive vinyl flooring for our operating rooms and adjacent areas.

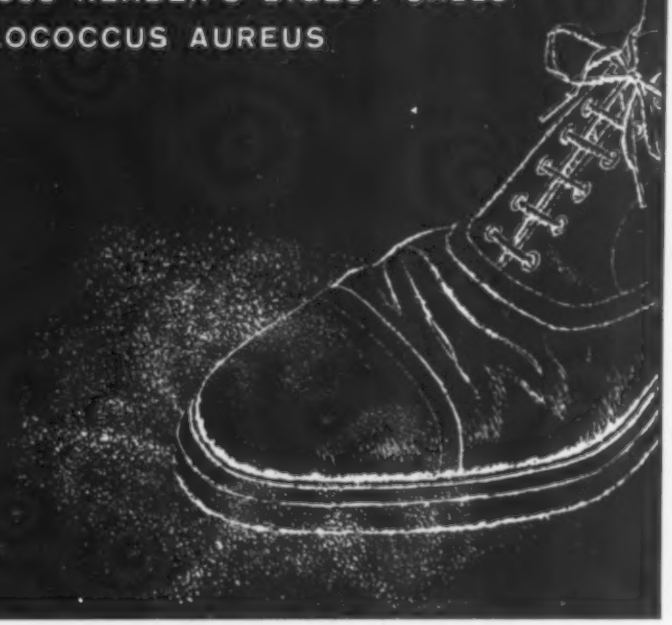
NAME _____

HOSPITAL _____

ADDRESS _____

"GOLDEN VILLAIN"

AS THE JANUARY 1958 READER'S DIGEST CALLS
STAPHYLOCOCCUS AUREUS



succumbs to Wescodyne's detergent-germicide action

WESCODYNE®

Air-borne bacteria that contain "Staph" and other organisms can be controlled by cleanup procedures with WESCODYNE, the first "Tamed Iodine"® Detergent-Germicide. A simple one step application kills staph germs quickly while removing soil and dust.

WESCODYNE is the single hospital germicide suitable for all disinfecting and sterilization procedures. It is nonselective. Destroys T.B., Polio, other viruses, bacteria, spores, fungi. This wide-spectrum biocidal activity offers a greater range of effectiveness than solutions containing chlorine, cresylics, phenolics or quaternaries.

WESCODYNE increases germicidal capacity to three to four times that of other germicides — as tested on successive kills of seven common organisms. It is nonstaining, nonirritating, nontoxic. Leaves no odor. Saves time and labor because it cleans as it disinfects.

WESCODYNE costs less than 2¢ a gallon at the general-purpose use dilution of 75 ppm available iodine. Sound worthwhile? Send the coupon for full information, including recommended O.R., housekeeping and nursing procedures.

Programs and Specialties for
Protective Sanitation and Preventive Maintenance

WEST CHEMICAL PRODUCTS INC.

WEST DISINFECTING DIVISION

WEST CHEMICAL PRODUCTS INC., 42-16 West Street, Long Island City 1, N. Y.
Branches in principal cities • In Canada: 5621-23 Casgrain Ave., Montreal

☐ Please send recommended procedures and full information on Wescodyne.
☐ Please have a West representative telephone for an appointment.

Name_____

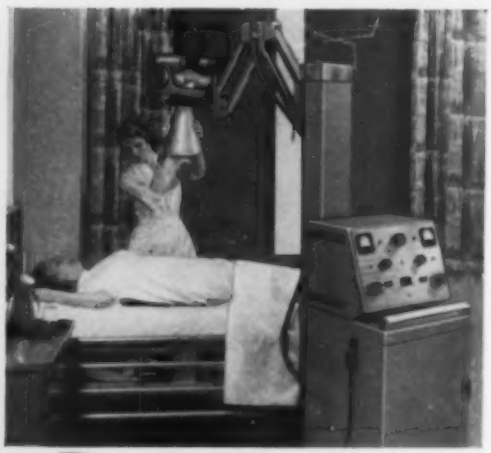
Position_____

Mail this coupon with your letterhead to Dept. 25

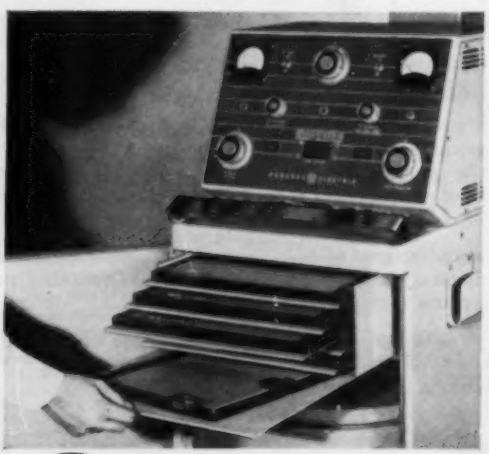
Putting full 200-ma power on wheels, this G-E unit brings new dimensions to x-ray versatility, as shown in . . .

the morning rounds

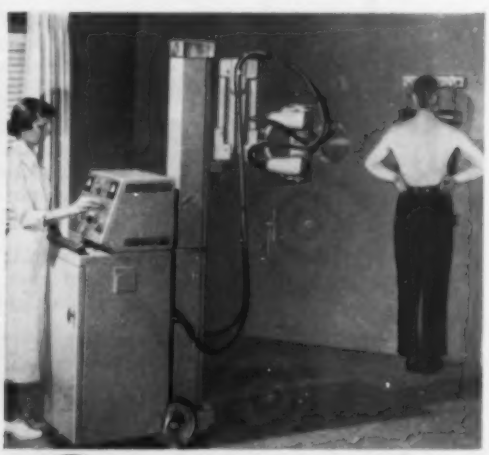
TO ROOM 234. Mobile "200's" full 200-ma, 100-kvp output provides the power and x-ray controls of fixed installations. Comparable film quality further assured by electronic timing.



OVER TO ORTHOPEDICS. Another G-E plus is flexibility in positioning. Full 360° vertical and horizontal tube rotation. Vertical travel nearly 6 ft. Up to 77-in. focal-spot-to-floor distance.



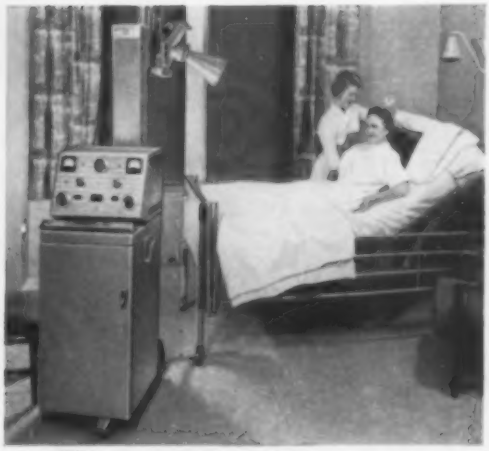
IN THE CAST ROOM. Ample storage space saves running back and forth for more cassettes. Convenient sliding drawers. Built-in circuits for easy adaptation to Bucky operation.



BACK IN THE DEPARTMENT. Mobile "200" can be used with a vertical cassette holder or other auxiliary facilities to speed work when fixed equipment is tied up and schedules fall behind.

# of a Mobile "200"

DOWN TO EMERGENCY ROOM to radiograph an accident case. Mobile "200," only 79 in. high, easily clears standard doors. Its maneuverability makes it ideal for work in cramped quarters.



FOLLOW-UP CHEST. Because the Mobile "200" operates from wall outlets, it can be used anywhere. Any adequate 230-volt line will do. And you can work from 115 volts at reduced power.

FIND out how the Mobile "200" can help you improve quality of service and expedite case handling. Let your G-E x-ray representative show you how the "200" can serve your particular requirements. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. H-31.

With its 90-kvp, 15-ma output, the economical Mobile "90" (at right) also provides "roll-anywhere" x-ray facilities.

Progress Is Our Most Important Product

GENERAL ELECTRIC

END DECEPTION

Your eyes can be easily deceived. They'll see a high gloss on floor finishes when the gloss really is on the floor itself; they'll tell you one finish lasts as long as another when there's a big difference in the wearing qualities of the two; they'll mislead you into believing your floors are well protected when the floors aren't protected at all.

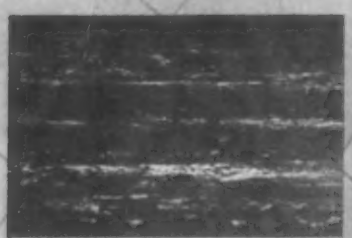
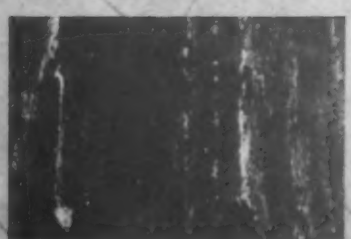
Why? Because the thin film left by floor finishes can't be seen. It's transparent. That's why the gloss you see may be a shine on bare tiles, not a shine on protective finish.

DON'T GUESS...KNOW

Now for the first time new tell-tale STYLE ends the guess work—gives you the true picture of the finish on your floors.

New STYLE with the "Performance Veri-fire" is invisible under ordinary light, but when you cast, safe easily-available black light (Long Wave Ultraviolet Illumination) on the new STYLE finish, it immediately glows—you see the finish. See the comparative photographs below of the 4 floor tile panels, each under ordinary light and under "black light."

WHAT YOU SEE

UNDER REGULAR LIGHT	UNDER BLACK LIGHT
	
Leveling appears to be good.	Leveling is actually poor.
	
Application looks uniform.	Proves application is uniform.
	
Finish shows no apparent wear.	Finish shows hard wear.
	
You can only guess if stripping has been complete.	If fluorescence is gone you know stripping has been complete.

What is STYLE?

STYLE is a completely synthetic floor finish consisting of long-wearing co-polymer plastic resins, dispersed in water emulsion form. Producing a longer-lasting, protective finish on floors, it is designed to replace self-polishing floor waxes. It has high water resistance — (permits damp mopping)—yet it is easily removed by ordinary wax stripping methods. A coating of STYLE is dirt-resistant and scuff-resistant—retains its initial brilliance longer than any wax product. This means lower labor costs while maintaining excellent appearance.

How does STYLE'S "Veri-Fire" Work?

Simple, very simple . . . a portable black light is held above the STYLE finished floor. Immediately, like a touch of magic, the looking glass fluorescence in the STYLE finish takes fire and TELLS:

1. If application is *complete* and *uniform*.
2. If good leveling has been obtained.
3. If the finish requires re-application.
4. If there's too much build-up.
5. If stripping has been complete.

Right before your eyes the *true* condition of the floor finish has been positively determined. You can then take the necessary steps as indicated by the black light analysis.

What does this Tracer mean to you?

It means that with the use of STYLE on your floors, you can keep tight control over your maintenance program . . . Eliminate wasted man hours . . . Eliminate excessive use of materials . . . This gives proof positive at all times that you have a quality product. This guarantees dollar savings to you.

Only STYLE Dares to Tell!

Only STYLE can risk the "Veri-Fire" Performance Tracer!

Only STYLE lets you see for yourself!

Look in the Looking Glass!

Without obligation we will send our representative and his "black light" to demonstrate right on your own floor that STYLE *is* a revolutionary product with revolutionary performance control . . . SEEING IS BELIEVING. Just write us on your letterhead. But do it TODAY.

VESTAL INCORPORATED

4963 MANCHESTER AVE.
ST. LOUIS 10, MISSOURI

WEST COAST PLANT • MODESTO, CALIF.
Vestal Products are Warehoused in all Principal Cities

Only American Cascade Unloading Washers have

"LOAD-LOK" CYLINDER DOORS

American has done it again!

Exclusive "Load-Lok" cylinder doors have greatly simplified one of the few remaining manual operations with Cascade Unloading Washers. Load-Lok Doors are unsurpassed in ease of operation, simplified maintenance and complete safety.

Easy to operate. A flick of the fingers releases latch at each side of door (Figure 1), and weight of door causes it to fold open into compartment (Figure 2). A simple push on bottom edge (Figure 2) latches door automatically in full open position, prevents any movement during loading and unloading.

Closing is just as easy. A slight push inward as latch is depressed (Figure 3) and door slides forward to half-closed position. A quick snap forward (Figure 4) and door automatically locks shut.

Simplified Maintenance. With no cylinder door bands and slides to adjust, repair or replace, and fewer expendable parts, Cascade Unloading Washers are easier than ever to maintain.

Complete Safety. Weight of door plus inward fold makes it impossible for door to close on operator's hand. Also, door cannot work loose during washing cycle, because the weight of the load in the compartment helps lock the door closed.

Labor-saving, high-production machines are the surest way to increased profits. For complete information on American Cascade Unloading Washer with exclusive Load-Lok cylinder doors, contact your nearby American Man from the Factory or mail coupon.

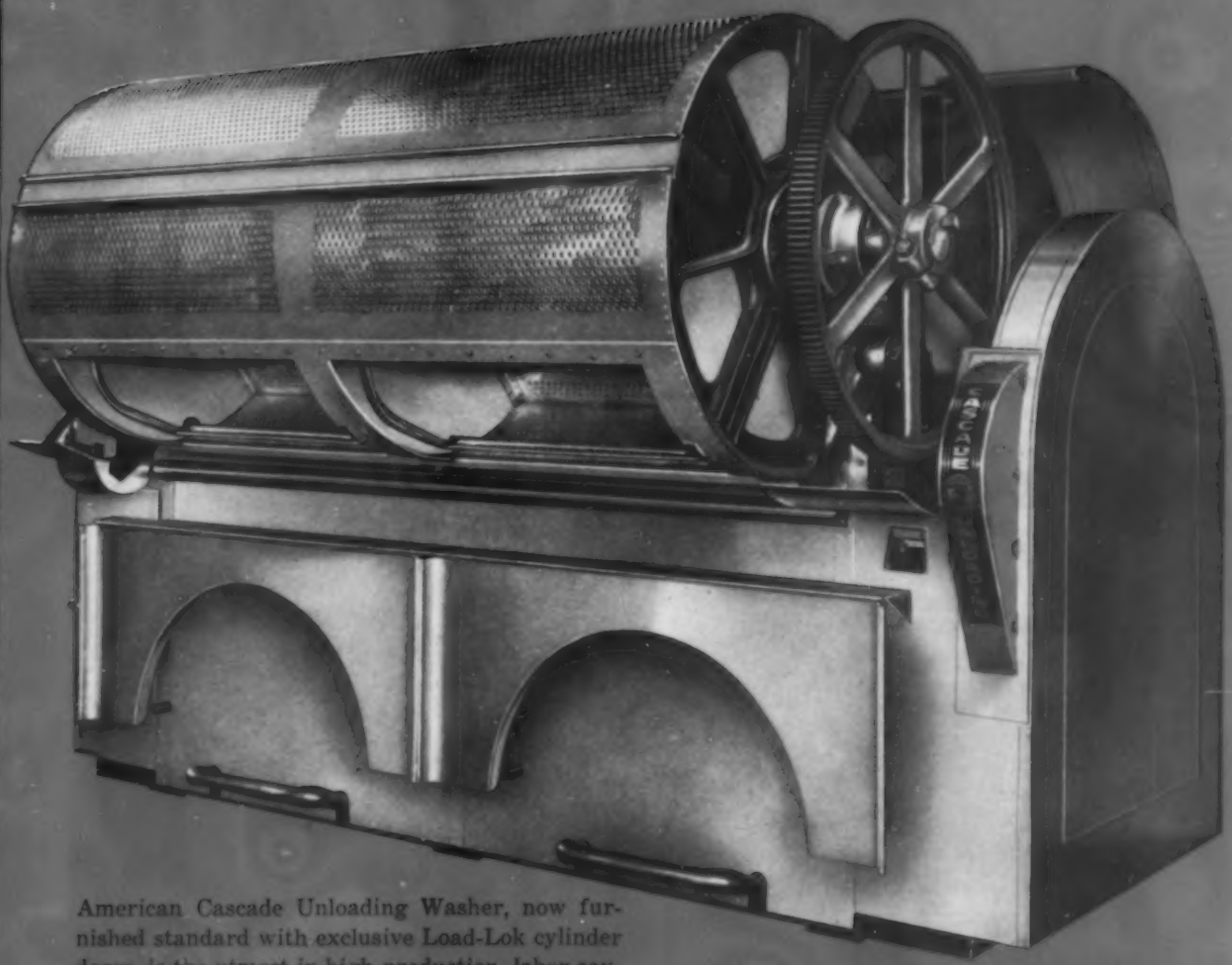
1

2

3

4

The American Laundry Machinery Company, Cincinnati 12, Ohio



American Cascade Unloading Washer, now furnished standard with exclusive Load-Lok cylinder doors, is the utmost in high-production, labor-saving laundry machinery. Automatic Washing Controls (furnished optional according to your particular requirements), and push-button unloading save labor, water and supplies, increase efficiency, allow each washman to handle more washers, and produce more washer loads per day.

CLIP AND MAIL TODAY!

The American Laundry Machinery Company, Cincinnati 12, Ohio ALM-516

Please send me Catalog AB 334-422 on the Cascade Unloading Washer with "Load-Lok" cylinder doors.

NAME_____

CARE OF_____

ADDRESS_____

CITY_____ ZONE_____ STATE_____

You get more from

American

NOW!

FAMED DEKNATEL SILK

in the proved

DEKNATEL PLASTIC PAK

- Proved in routine hospital use with Deknatel Surgical Gut.
- Requires no change in your sterile technique.
- Sterilize in formaldehyde as you have always done with glass tubes.
- Eliminate the hazards of glass with the hermetically-sealed Deknatel Plastic Pak—proved to give you all the reliability of glass.
- Use Deknatel Surgical Silk—long acknowledged the leader because of its strength and uniformity.

MAKE THIS SIMPLE "SQUEEZE TEST"

as thousands of others have done. Squeeze a Deknatel Pak with all the strength of your fingers . . . prove to yourself that it will not leak.

AN IMPORTANT STATEMENT

—from a feature article in America's foremost packaging magazine about Deknatel Plastic Pak:
". . . *The halofluorocarbon formulation used by Deknatel is rated as completely impermeable (no weighable loss in 90 days or more) to water, acetic acid, ethyl alcohol, methyl alcohol, formaldehyde, hydrochloric acid and sodium hydroxide . . .*"

From: "Enter Fluorocarbon Film", Modern Packaging Magazine, November 1957. Complete article available upon request.

For sample, write:

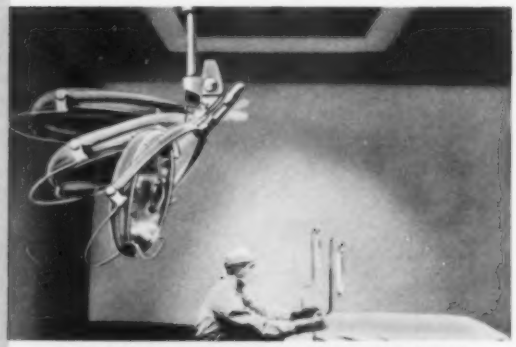
DEKNATEL · PLASTIC PAK

96-26 222 Street, Queens Village 29, New York

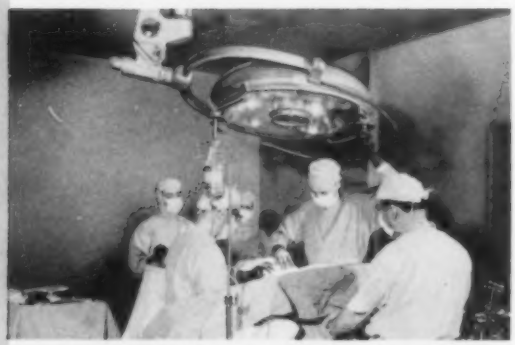

ANOTHER USEABLE
ACHIEVEMENT BY
Castle

ANOTHER USEABLE ACHIEVEMENT

Largest Area Coverage—Light rotates at finger touch through 8'3" circle—largest area coverage of any single dome major operating light.



Self Locking—Internal Cam Balance allows vertical descent, holds light in position placed. Eliminates hazardous counterweights.



For All Surgical Procedures—Surgeon or assistant may adjust light easily and quickly as the operative field changes.

Pre-Operative Guide—"60 Series" Lights have color corrected, heat filtered, separately controlled center spotlight. Used here as pre-operative illuminating guide.

The Castle "60 Series"

(Nos. 61-66)

LIGHT CONTROL BY THE SURGICAL TEAM

The first major operating lights for direct control by the surgical team. Here at last is unequalled Castle illuminating quality wed to unsurpassed mobility and positioning range.

You will agree: this is a *useable* achievement!

Surgical Light Where, When and How You Want It

The Castle "60 Series" Light can be directed exactly *where you want it!* Here's how it works: One large dome houses four separate pre-focused reflectors. Each directs 28 beams into the cavity . . . a total of 112 precisely controlled illuminators, each converging on the cavity from a different angle. Result: even the deepest incision is illuminated with a gentle flow of useable light. There's almost no glare, and despite necessary interference of head, shoulders and hands, you work without shadow. This is surgical light directed only *where you want it.*

With a Castle "60 Series" Light you or your assistants can control the surgical illumination without breaking surgical technique. Fine adjustments are made in seconds—at a finger's gentle touch of sterile handles. Light is beamed instantly where it is needed . . . This is useable surgical light . . . *when you want it!*

How do you want your surgical light? Cool? Each lamp inside the dome is housed in its own heat-absorbing filter, keeping the surgical area comfortable. Continuous? Adequate light remains to complete an operation should one, two or even three bulbs burn out during surgery. Like daylight? The Castle color correction filter is so exact that color pictures may be successfully taken with a special camera attachment, and with no need for auxiliary lighting . . . *Write for descriptive folder.*

WILMOT CASTLE COMPANY
BOX 629 • ROCHESTER, N. Y.

1883
1958

Diamond Jubilee Anniversary

Castle

PIONEERS IN SURGICAL EQUIPMENT SINCE 1883

Printed in U.S.A.

SINCE 1860

DESIGNED BY AND FOR NURSERY SUPERVISORS...

THE ENTIRELY NEW ALOE INFANT INCUBATOR

NO OTHER INCUBATOR PROVIDES SO MANY OUTSTANDING FEATURES AT SUCH REASONABLE COST

Aloe alone offers all six of these features:

1) **Explosion proof.** Can be used even when explosive anesthetic gases are present.
2) **Easily Mobile.** Permits quick transfer of baby from delivery room to nursery.
3) **Regulates oxygen concentration.** So vitally important in preventing retrolental fibroplasia.
4) **Has completely simple one knob control.**
5) **Readily accessible from top and side.**
6) **Heating element and thermostat in completely sealed unit.** Easy to remove from cabinet in a few minutes, should replacement ever be necessary.

Mail the coupon today for illustrated brochure about the new Aloe Infant Incubator, or about the complete line of outstanding Aloe nursery equipment, if you are planning to equip a nursery.

a. s. aloe company
World's Foremost Hospital Supplier

1831 OLIVE STREET
ST. LOUIS 3, MISSOURI
14 FULLY-STOCKED
DIVISIONS FROM
COAST TO COAST

A. S. Aloe Company, Dept. 105
1831 Olive Street, St. Louis 3, Mo.

I would like to receive additional information about ☐ the Aloe Infant Incubator, ☐ the complete line of Aloe Nursery Equipment. (Please check here ☐ if you are equipping or planning to equip a nursery.)

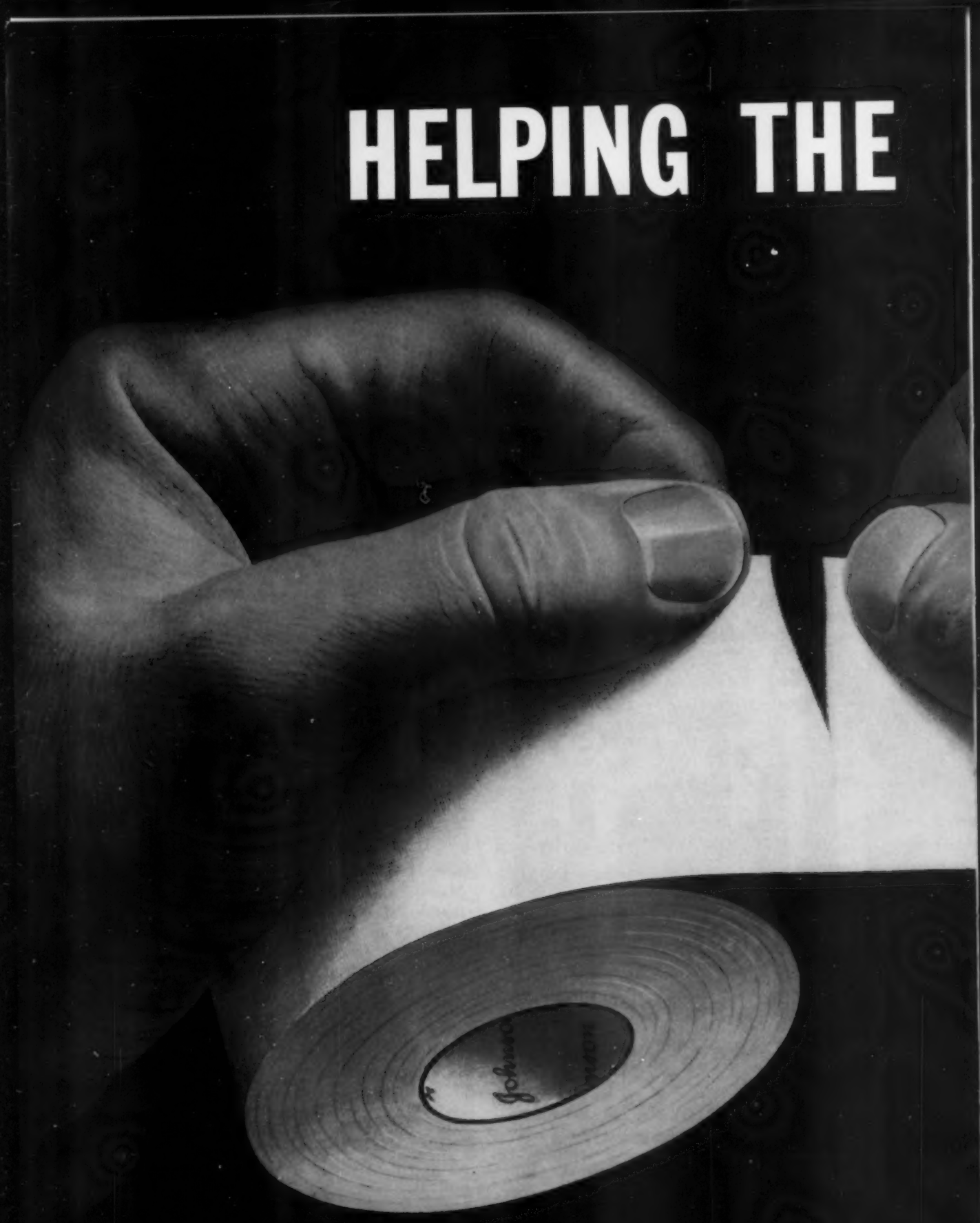
Name_____ Title_____

Hospital_____

Address_____

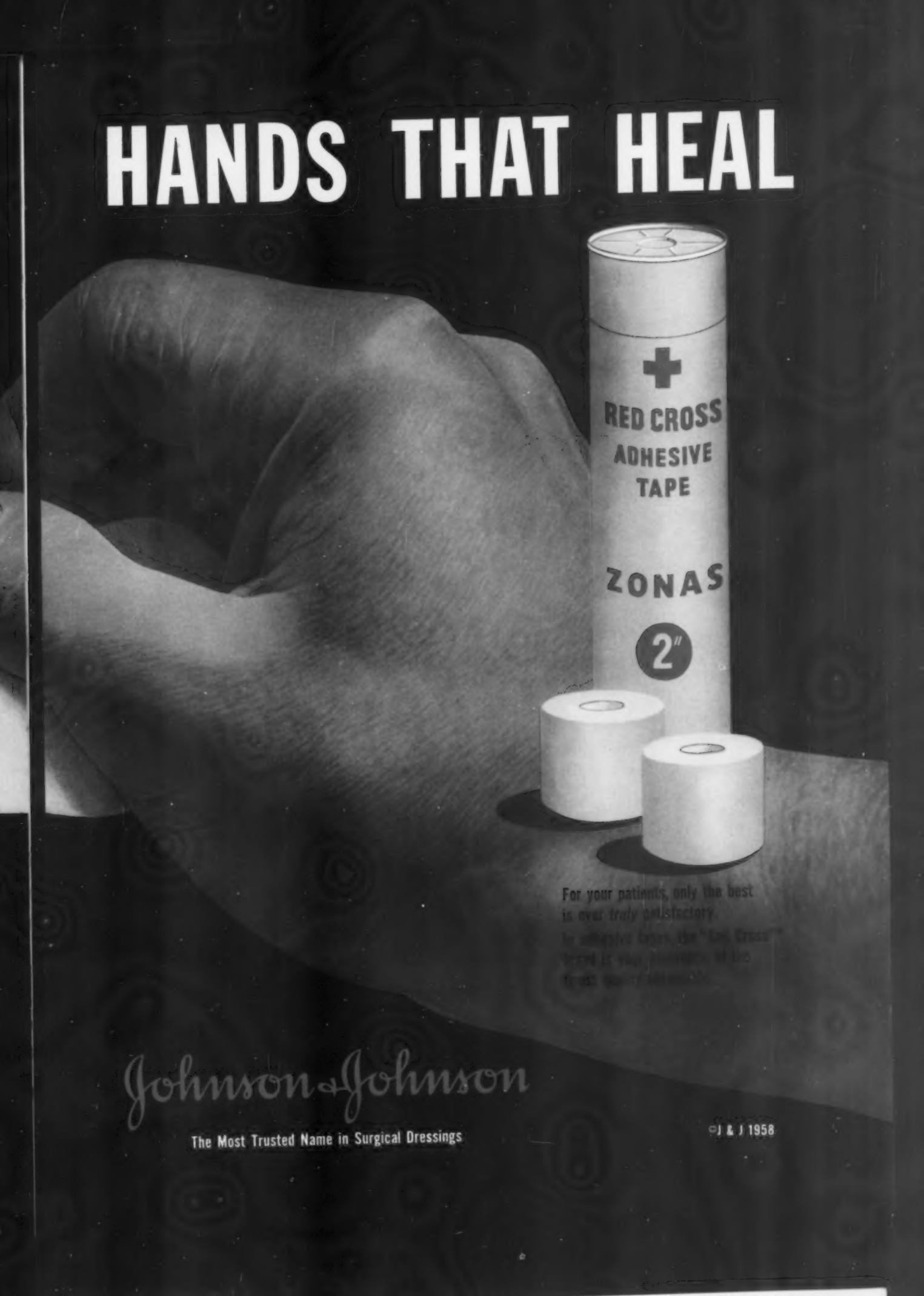
City_____ Zone____ State_____

HELPING THE



*No connection whatever with American National Red Cross.

HANDS THAT HEAL



For your patients, only the best is ever truly satisfactory

Johnson & Johnson

The Most Trusted Name in Surgical Dressings

MINIMUM REQUIREMENTS FOR SURVIVAL--CIRCA 1812

In 1812 you might have survived an illness because of the sheer number of remedies prescribed against it. But there was no guarantee you would survive the remedies.

Luckily, diagnosis is no longer a hit-or-miss proposition. Many of today's cures start with accurate radiology. That's why so many medical people have a standard prescription for radiological accuracy.
Their prescription is—*Ansco X-ray Films.*

Ansco X-ray Films are, of course, best known for their diagnostic readability. A readability that has grown out of this superb film's ability to separate the subtlest gradations in tissues and bone, making diagnosis an easier, surer job.
In any comparison between Ansco X-ray Films and any other film, you will see the difference . . . *Clearly!*

Ansco

X-ray

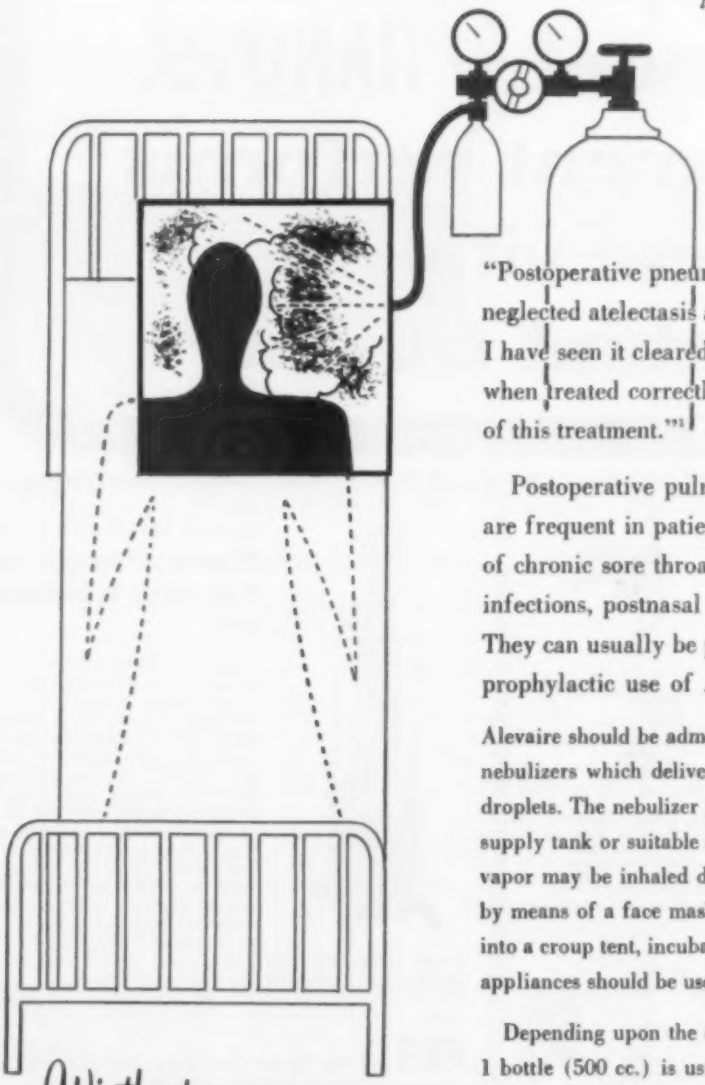
Ansco, A Division of General Aniline & Film Corporation, Binghamton, N. Y.

prevent

POSTOPERATIVE PULMONARY COMPLICATIONS

with **ALEVAIRE®**

Nontoxic Mucolytic Mist



"Postoperative pneumonia is almost always neglected atelectasis and must be treated as such. I have seen it cleared up within a few hours when treated correctly. Alevaire is part of this treatment."[1]

Postoperative pulmonary complications are frequent in patients with a history of chronic sore throat, chronic cough, sinus infections, postnasal drip or heavy smoking. They can usually be prevented by the prophylactic use of Alevaire.

Alevaire should be administered only by aerosol nebulizers which deliver a fine mist without large droplets. The nebulizer is attached to an oxygen supply tank or suitable air compressor. The Alevaire vapor may be inhaled directly from the nebulizer by means of a face mask, or it may be delivered into a croup tent, incubator or special tent; only those appliances should be used which deliver a fine mist.

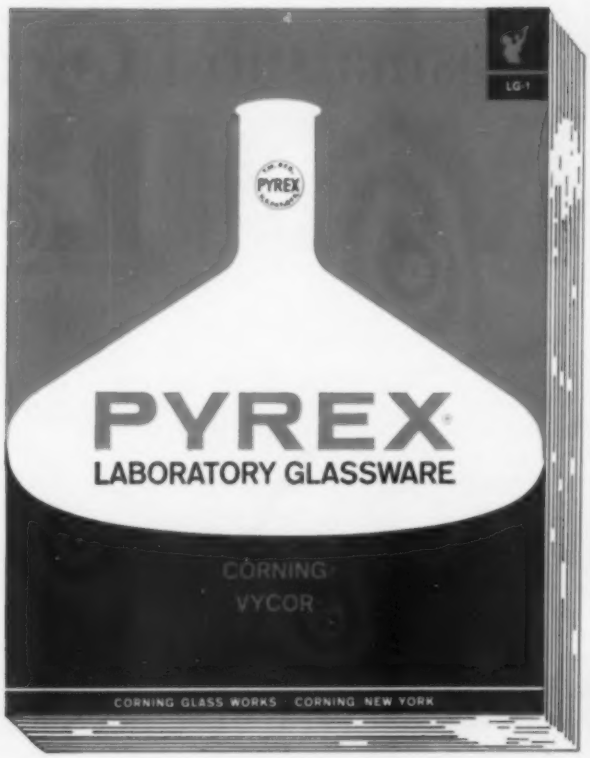
Depending upon the output of the nebulizing device 1 bottle (500 cc.) is usually sufficient to last from eight to twenty-four hours.

Supplied in bottles of 60 cc. and 500 cc.

Winthrop LABORATORIES
NEW YORK 18, N.Y. • WINDSOR, ONT.

1. Sadove, M.S.: Paper read at Meeting of the Champaign County Medical Society, Champaign, Ill., Mar. 12, 1953.

Alevaire, trademark reg. U. S. Pat. Off.



HOT OFF THE PRESS!

The most complete labware catalog ever!

350 Pages . . . 8500 Pieces of PYREX® Borosilicate Lab Glassware

New listing method and color-coding make Corning's NEW Catalog even easier to use

This newly published Corning Catalog of PYREX brand Laboratory Glassware is the most complete, easiest-to-use book of its type ever printed.

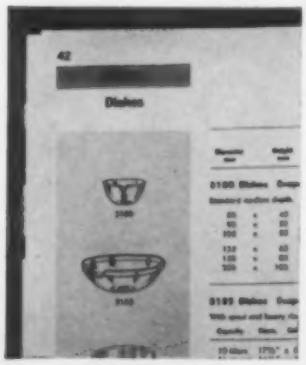
The idea originated with you. If you were one of the customers we contacted in our Catalog Preference Survey it's likely your ideas are incorporated in Catalog LG-1. Because you use it frequently it was only fair that you had a say in its organization and layout.

For fast finding—new listing method. LG-1 is set up dictionary style. Bold headings at the top outside corner of each page tell you the class of ware and the type of glass of the products listed on that page . . . let you locate any item in the book in just seconds.

For fast finding—color-coded Sections. The Catalog is in six Sections, each with its own color panels at the top and side of each page. For example, the panels in the PYREX® Section are green; VYCOR® Section, blue; Custom Made Section, brown. Merely flip the pages to find what you need.

There's an extensive index and exhaustive cross-indexing, too, so you can find similar items and component parts quickly. Three separate Appendixes (A.S.T.M. Ware, Micro, and Needle Valve Ware) also improve "finding" efficiency.

Custom Made Labware Section. Also at your request, the former Custom Apparatus Catalog joins our Standard Listings. This 143-page Section lists the most demanded modifications of all types of ware. Each item differs from the norm in ways to make your work faster or easier. Included, also, are 13 pages of Micro Ware and 12 pages of Needle Valve Equipped Glassware listings.



Most complete line available anywhere. Flasks, for example, are listed in all six sections.

No eyestrain: LG-1 is color-coded. Each section has its own color panels and is identified in print.

Easy-to-find illustrations. Just flip the pages to find what you need.

Clip the Coupon for Your Free Copy of LG-1, Corning's New Lab Glassware Catalog

Corning means research in Glass

CORNING GLASS WORKS
38-3 Crystal Street, Corning, New York

I have not as yet received my free copy of Corning Catalog LG-1. Please send me one.

Name..... Title.....

Company.....

Street.....

City..... Zone..... State.....

hepatitis-free blood plasma substitute:

PLAZMOID*

brand of gelatin solution

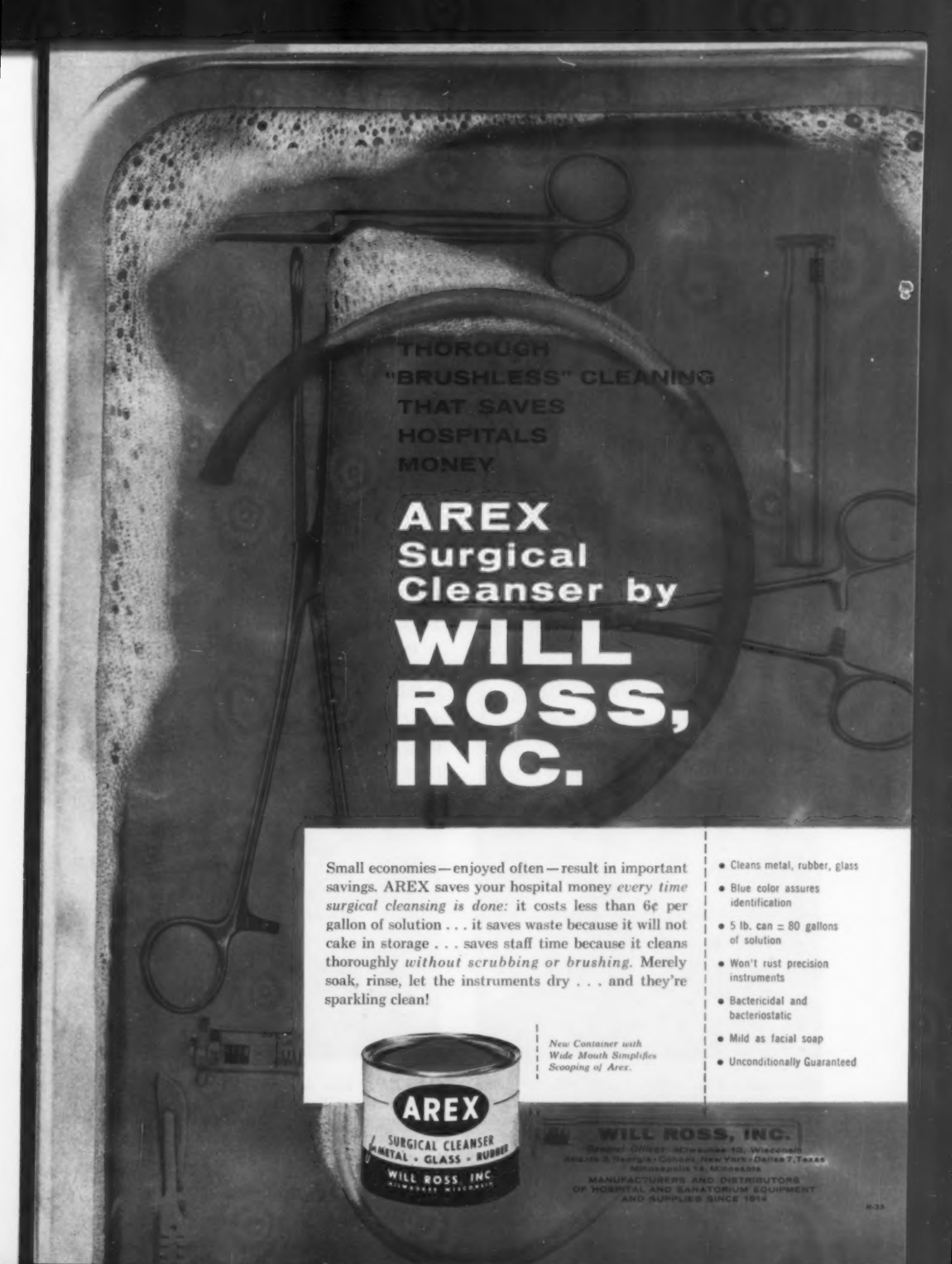
Upjohn

THE UPJOHN COMPANY
KALAMAZOO, MICHIGAN

Plazmoid is purified gelatin in isotonic solution of sodium chloride. It parallels plasma in colloidal osmotic effects, yet is much less expensive, and free of the possibility of transmitting serum jaundice.

Available in bottles of 500 cc.

*TRADEMARK REG. U. S. PAT. OFF



Small economies—enjoyed often—result in important savings. AREX saves your hospital money *every time surgical cleansing is done:* it costs less than 6¢ per gallon of solution . . . it saves waste because it will not cake in storage . . . saves staff time because it cleans thoroughly *without scrubbing or brushing.* Merely soak, rinse, let the instruments dry . . . and they're sparkling clean!

- Cleans metal, rubber, glass
- Blue color assures identification
- 5 lb. can = 80 gallons of solution
- Won't rust precision instruments
- Bactericidal and bacteriostatic
- Mild as facial soap
- Unconditionally Guaranteed

New Container with Wide Mouth Simplifies Scooping of Arex.

WILL ROSS, INC.

General Offices: Milwaukee 10, Wisconsin
Atlanta 3, Georgia • Conover, New York • Dallas 7, Texas
Minneapolis 14, Minnesota

MANUFACTURERS AND DISTRIBUTORS
OF HOSPITAL AND SANATORIUM EQUIPMENT
AND SUPPLIES SINCE 1914

R-33

Now from Carrier...

A NEW LOW-COST WAY TO AIR CONDITION PATIENT ROOMS

without major alterations or interruptions!

Now existing hospitals have the opportunity to obtain the benefits of year-round central air conditioning without extensive alterations and high first costs. Carrier, leader in air conditioning, has developed the means in its new Model 36P high-induction Room Weathermaster* Units.

These attractive units replace existing radiators. They combine an all-air high-velocity system with existing steam heating services to eliminate the installation costs of insulated chilled water lines, condensate drains and new electric service to every room. They also eliminate the cost of cutting multiple small openings in exterior building walls. The system can be installed quickly, easily and economically at your convenience.

Like all Carrier Weathermaster Units, the new Model 36Ps provide year-round individual climate control in each room at the turn of a dial. They assure constant draftless air circulation and positive ventilation without cross circulation between rooms. They are quiet and easy to maintain, with no moving parts in the room.

Is this new way best for every hospital?

That depends on the condition of the hospital's existing steam services. If the steam lines are in good condition, the new Carrier

BEFORE: This unsightly, old-fashioned radiator detracted from the appearance of the patient's room. Besides being a dust trap, its only function was to furnish heat.

AFTER: This attractive Carrier 36P Room Weathermaster Unit provides year-round air conditioning and heating. Three types of cabinets for various room and window arrangements.

36P Weathermaster System is the best way, since the existing services will be incorporated in the complete air conditioning plant. However, if the steam services are ready for replacement, the Carrier Modular Weathermaster System is undoubtedly best.

In the widely used Modular Weathermaster System, Model 36N Units replace radiators. These units employ a primary high-pressure air circuit plus a secondary water circuit through which chilled or hot water is circulated, depending on the season. Worn-out steam lines are replaced by modern copper water piping that will provide years of trouble-free service.

No matter what problems a hospital poses, there's a Carrier system to meet all requirements efficiently and economically. A Carrier expert will be glad to advise which way is best for you. For information, just call your nearest Carrier office. Or write Carrier Corporation, Syracuse, New York.

Carrier

AIR CONDITIONING
REFRIGERATION
INDUSTRIAL HEATING

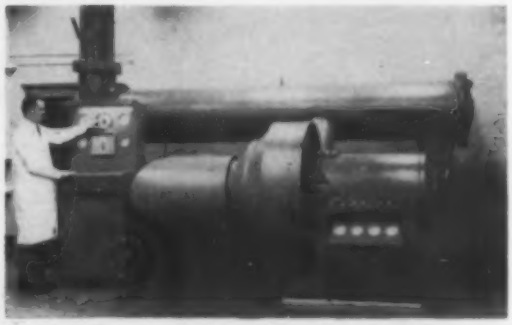
*Reg. U.S. Pat. Off.

WHICH REFRIGERATION IS BEST FOR YOUR AIR CONDITIONING?

Whichever Carrier Weathermaster System is best for your hospital, there's also need for a refrigerating machine. The choice depends on several factors. Where should it be located? What kind of power is available? How much tonnage do you need? Carrier builds every type of refrigeration for air conditioning. Two of many types are shown here. Each provides unique advantages under special conditions. Each has been proved practical and dependable in installation after installation.

If you have low-cost steam, Carrier's new Absorption Refrigeration Machines may be best. They use heat energy from low-pressure steam or hot water to produce cooling. Operation is automatic, quiet and vibration free. Light and easy to install. Cooling capacities: 60 to 700 tons.

If you have low-cost electric power, new Hermetic Centrifugal Refrigeration may be the answer. These machines are compact and light in weight. Electronic controls provide continuous, automatic chilling of water to the desired temperatures. 90 to 1100 tons.



CARRIER CORPORATION
SYRACUSE NEW YORK

THE LABEL *IS* IMPORTANT!

In the Puritan tradition of ceaseless improvement, a new Puritan cylinder label is now in use.

In addition to its handsome, modern design, the Puritan label offers two important benefits to the user:

Vivid, distinctive colors which clearly and unmistakably identify the gas contents.

For your protection, cylinder and content weights are entered on every label, rather than on tags.

This new label is additional evidence of Puritan's interest and care in providing you with the finest products and service in the medical gas field.

Puritan

COMPRESSED GAS CORPORATION
SINCE 1913
KANSAS CITY 8, MO.

PRODUCERS OF MEDICAL GASES AND GAS THERAPY EQUIPMENT

Tetrex

TETRACYCLINE PHOSPHATE COMPLEX

Bristol

24-hour blood levels

on a **SINGLE** intramuscular dose, in minimal injection volume

This achievement is made possible by the unique solubility of TETREX (tetracycline phosphate complex), which permits *more* antibiotic to be incorporated in *less* volume of diluent. Clinical studies have shown that injections are well tolerated, with no more pain on injection than with previous, less concentrated formulations.

TETREX Intramuscular '250' can be reconstituted for injection by adding 1.6 cc. of sterile distilled water or normal saline, to make a total injection volume of 2.0 cc. When the entire 250 mg. are to be injected, and minimal volume is desired, as little as 1.0 cc. of diluent need be used. (Full instructions for administration and dosage for adults and children, accompany packaged vial.)

Each one-dose vial of TETREX Intramuscular '250' contains:

TETREX (tetracycline phosphate complex) (tetracycline HCl activity)..... **250 mg.**

Xylocaine* hydrochloride ..... **40 mg.**

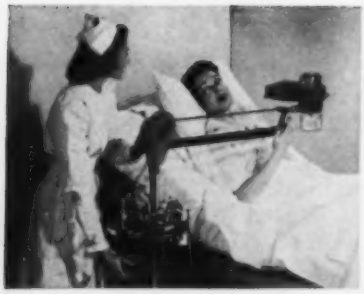
plus ascorbic acid 300 mg. and magnesium chloride 46 mg. as buffering agents.

**® of Astra Pharm. Prod. Inc. for lidocaine*

SUPPLY: Single-dose vials containing TETREX – tetracycline phosphate complex – each equivalent to 250 mg. tetracycline HCl activity. Also available in 100-mg. single-dose vials.

INTRAMUSCULAR '250' WITH XYLOCAINE

BRISTOL LABORATORIES INC., SYRACUSE, NEW YORK



Inhalation therapy: The HYDROJETTE®, is an ideal open-air humidifier for treatment of upper respiratory complications, useful also as a suction pump, and may be rolled quietly to the patient's bedside.

In the pediatric ward: First "cool-vapor" and oxygen tent, the CROUPETTE® is standard equipment in 83% of all hospitals in the United States accredited for residency training in pediatrics.

In the operating room: The JEFFERSON VENTILATOR automatically and continuously ventilates the patient under closed or semi-closed circuit anesthesia. A time-cycled, pressure-limited, automatic device, the JEFFERSON VENTILATOR maintains pressures preset by the anesthesiologist. Vertical scale shows delivered volume. Simplicity and dependability of operation with independent controls for phase, rate, positive and negative pressure are outstanding features.

Regulated suction: The rugged, portable DIA-PUMP is a diaphragm-type suction pump. Designed for continuous, heavy-duty operation, it cannot jam, rust or "freeze," even from condensed or aspirated moisture, and is equally valuable as a compressor to operate the CROUPETTE.

How AIR-SHIELDS products

In postnatal asphyxia: The ISOLETTE® ROCKER is designed for use in the nursery for non-traumatic treatment of the apneic newborn. A mechanical application of the Eve method of resuscitation, the ISOLETTE ROCKER provides gravitational stimulation of the circulation and passive, rhythmic activation of the diaphragm to aid ventilation within the optimal environment of the ISOLETTE incubator.

In the nursery: The ISOLETTE® infant incubator provides the life-saving benefits of true isolation with accurate control of humidity and temperature. Only the ISOLETTE continuously draws in fresh, pathogen-free air from outside the hospital, protecting the infant from air-borne infections even when the iris ports are open. The ISOLETTE is designed to perform, and built to last. The ISOLETTE is used in teaching hospitals affiliated with more than 95% of medical schools and colleges throughout the United States and enjoys wide acceptance in 70 other countries as well. First in its field, the ISOLETTE has been widely copied but never equalled.

can help save lives in your hospital

In the nursery, the operating or delivery room, the pediatric ward, and for general use throughout the hospital, AIR-SHIELDS equipment is helping save lives and comfort patients in many ways.

The ISOLETTE® infant incubator and isolation unit provides the optimal environment necessary for survival of the tiny or critically ill infant, and minimizes the danger of cross-infection in the nursery. The CROUPETTE® and HYDROJETTE® are unexcelled for the convenient, safe administration of cool-vapor therapy, with or without oxygen, to the infant as well as the adult. And, to help prevent respiratory acidosis during general anesthesia, AIR-SHIELDS research and engineering has developed the JEFFERSON VENTILATOR.

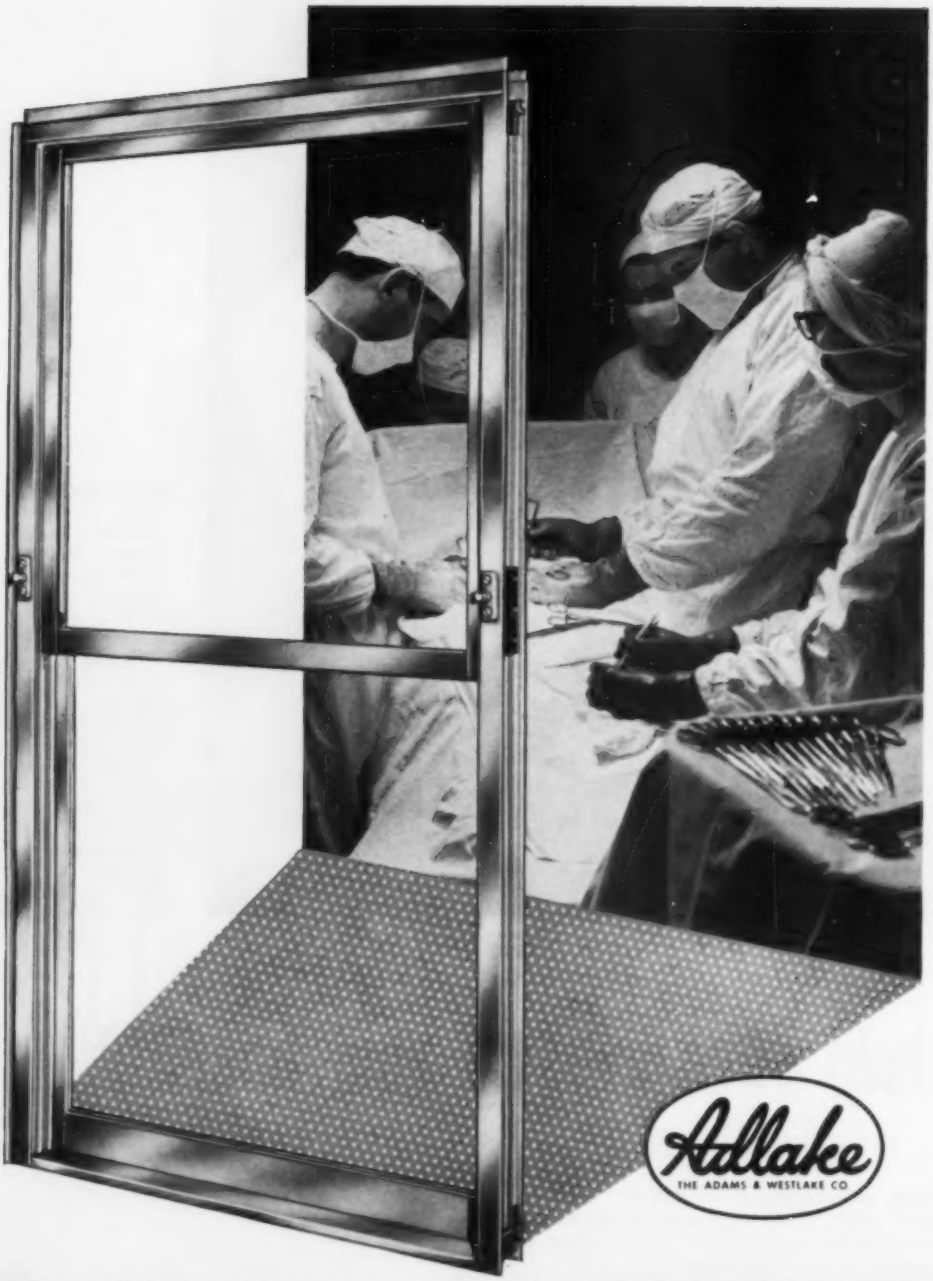
All AIR-SHIELDS equipment may be ordered with our unique 30-day return order privilege. For information write or phone us collect from any point in the United States. AIR-SHIELDS, INC., Hatboro, Pa. (OSborne 5-5200). In Canada: AIR-SHIELDS (CANADA), LTD., 8 Ripley Avenue, Toronto 3, Ont. (Roger 6-5444).

AIR-SHIELDS, INC.

Hatboro, Pa.

REPRESENTATIVES IN SEVENTEEN CITIES THROUGHOUT THE COUNTRY

Isolette, Croupette, Hydrojette, Vapojette and **Rockette** are registered trade marks of Air-Shields, Inc.



Adlake Windows are in this picture, too

Interpretation of the architect's exterior scheme is only half of the contribution of Adlake aluminum windows. Here are windows which admit no water, and minimum air, for indoor comfort... windows which produce no distracting rattle, and open at a finger touch... windows that will never cost a cent for maintenance or painting. See our 36-page listing in Sweet's Architectural File, or write—

Building Hospital for Special Surgery, New York City
Architect Rogers & Butler
Contractor Vermilya-Brown Company, Inc.
Type Adlake Double-hung Windows

The Adams & Westlake Company

NEW YORK • ELKHART, INDIANA • CHICAGO

SMALL HOSPITAL QUESTIONS

Private Room Ratio

Question: When our hospital was remodeled and rebuilt several years ago, we went "overboard" for the belief that the big demand in the future would be for semiprivate rooms. As a consequence, we find many beds in these rooms are not occupied, while the demand for single rooms has frequently exceeded the number of these rooms. Some of the doctors now think we should go to the additional expense of making further alterations to cut down the number of semiprivate beds, and add to the supply of private beds in line with what appears to be the demand. Are there any rules or standards that would help us determine the right thing to do?—R.S.R., Wis.

ANSWER: The only sensible rule is that each hospital community or neighborhood or service area has its own economic pattern, and there is no guide that is more reliable than your own experience, which at the moment would indicate you are oversupplied with semiprivate and undersupplied with private room beds. However, you should be guided, in addition, by these factors: (1) What is the outlook for further growth of Blue Cross membership and insurance coverage in your area? If the Blue Cross plan in your community anticipates substantial or rapid growth in the future, this might possibly affect the proportion of semiprivate to private rooms used, and you should check with Blue Cross before making a decision. (2) What is the economic outlook for your community for the next few years, as far as it can be predicted? While there is always some uncertainty about employment for a particular community, as for the country as a whole, business and industrial leaders in your town should be able to tell you what they anticipate in the way of future growth, employment and business conditions generally. If the outlook is generally good, you may expect the demand for private rooms to continue; however, if business conditions are uncertain and there is a likelihood of slack employment in the years ahead, you may find your present ratio of accommodations will be more nearly in line with public demand in the future than it has been in the past few years.

Finally, you should break your experience down by departments. The demand for semiprivate accommodations in obstetrical departments in most hospitals is greater than the demand for these accommodations in the medical and surgical departments, and you should be sure these variations are considered when you are deciding what changes to make for the future.

Employe to Be Retired

Question: We have a long-time employe who is now caretaker for our building and grounds. He is nearly 70 years old, and tends to spend a great deal of time acting as an unofficial "doorman" for the hospital, visiting with patients and visitors who come in, most of whom he knows as an old resident of the community. Frankly, we think the time has come for him to retire but he is resisting, and we are fearful that a positive move would result in bad public relations for the hospital, because of his wide acquaintanceship in the community. Is there some way we can handle this situation without loss of friends for the hospital?—C.H.N., Colo.

ANSWER: It is assumed you do not have a formal retirement plan but would make some appropriate arrangement for this employe in recognition of his long years of service. If this is the case, the retirement should be effected in the interest of efficient operation of the hospital; a natural concern for what people will think cannot be carried to the point of interfering with orderly conduct of the hospital's business. Furthermore, as long as the employe in this case is treated fairly and considerately, you will find the hospital will not be criticized for taking the proper action. On the contrary, most of those who know or care about it at all will commend you for fulfilling your first obligation—to spend the hospital's money wisely to produce the maximum service for patients.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Mechanization

Question: Does mechanization really offer an institution the best opportunity for reduction of maintenance costs?—G.O., Tenn.

ANSWER: Not necessarily. When considering a change in methods it is wise to make a thorough survey of the whole program: job analyses, time and motion studies, area surveys, frequencies, availability and adaptability of machines, personnel, supervision and comunication, training methods, inspection, materials, and so forth. Any or all of these may point ways to cost reduction or improved service.

A good practice in any work program is to use the biggest and best tool available, hand or machine. Poor tools, poor results! When planning any work program ask yourself these questions: (1) What is to be done? (2) Why? (3) When? (4) How? (5) Who?

When you apply the right answers you will get maximum results at the lowest possible cost.

Building Plans

Question: In planning new buildings, where does the superintendent of buildings and grounds fit into the picture?—F.L., Iowa.

ANSWER: The superintendent of buildings and grounds should be an integral part of the group involved in the planning of new buildings. He should have full opportunity to present his views, from the maintenance and operation angle, to the architects and engineers, as well as to the building committee, in all stages of the design. His knowledge of local and hospital conditions can be used to advantage in avoiding costly errors in construction.

Since in all probability he will be called upon to operate and maintain the structure upon its completion, it is essential that he be thoroughly informed on all discussions concerning the building from the original conception through to completion. Often, he will be the day-to-day point of contact between the building committee, the administration, and the architects.

These suggestions presuppose that the superintendent has a background in architecture or engineering or, lacking that background, a thorough knowledge of building operation and maintenance.

Dollar-wise buyers save money with

NIBROC®

THE BALANCED TOWEL

Whatever your preference, your dollar buys maximum value in Nibroc towels. Choose from Nibroc in the natural shade (multi-fold and single-fold) and Nibroc white in the new "white magic" finish (multifold and C-fold).

Why do Nibroc towels mean extra savings for you? Because no other towel combines in such perfect balance these three essential qualities—absorbency, wet strength, softness. Lint-free performance, too. And you save even more when you buy with Nibroc Sofwite® or Softan® tissue. Look under "Paper Towels" in Yellow Pages for name of nearest distributor. Or, write Dept.PN-3,Boston.

BROWN COMPANY

150 Causeway Street, Boston 14, Mass.
Mills: Berlin & Gorham, New Hampshire

WEIS

VITRE-STEEL

PORCELAIN ENAMEL TOILET COMPARTMENTS

chosen for today's buildings

Weis *Vitre-Steel* toilet compartments, finished inside and out in vitreous porcelain enamel (fired, not baked), have several distinct advantages over other materials for today's buildings. They don't break, stain or present costly installation problems . . . whether floor braced or ceiling hung. Too, there's a wide choice of colors to harmonize with any decorating plan. See Sweet's Architectural File, No. **22b/We** . . . or send coupon below for complete information.

TYPICAL INSTALLATIONS

MURCHISON TOWER—Denver, Colorado
LOVE FIELD AIRPORT—Dallas, Texas
UNION PACIFIC R.R. HDQRS.—Omaha, Neb.
SEAGRAM OFFICE BUILDING—New York City
HUNTINGTON ORTHOPEDIC HOSPITAL—Huntington, W. Va.
ST. LUKE'S CHURCH—Mountain Brook, Ala.
TOK SCHOOL—Tok, Alaska
ST. GERTRUDE'S ACADEMY—Cottonwood, Idaho
FIRE STATION #23—Cleveland, Ohio
TECHNICAL HIGH SCHOOL—El Paso, Texas
SHERMAN ELEMENTARY SCHOOL—Oakland, Calif.
YALE & TOWNE MFG. COMPANY—Monroe, N.C.
LYONS TOWNSHIP HIGH SCHOOL—Chicago (suburban), Ill.
STANDARD OIL COMPANY—Clayton, Mo.
Y.M.C.A.—Muscatine, Iowa
M.I.T. LABORATORY—Cambridge, Mass.

HENRY WEIS MANUFACTURING CO., INC.
Dept. H-1703, Elkhart, Indiana

Please send catalog and specifications of the complete line of Weis toilet compartments.

name

firm/institution

address

city/state

☐ have sales representative contact.

THE VAST MAJORITY OF THE NATION'S FINE BUILDINGS ARE SLOAN EQUIPPED

CARSON & LUNDIN
architects

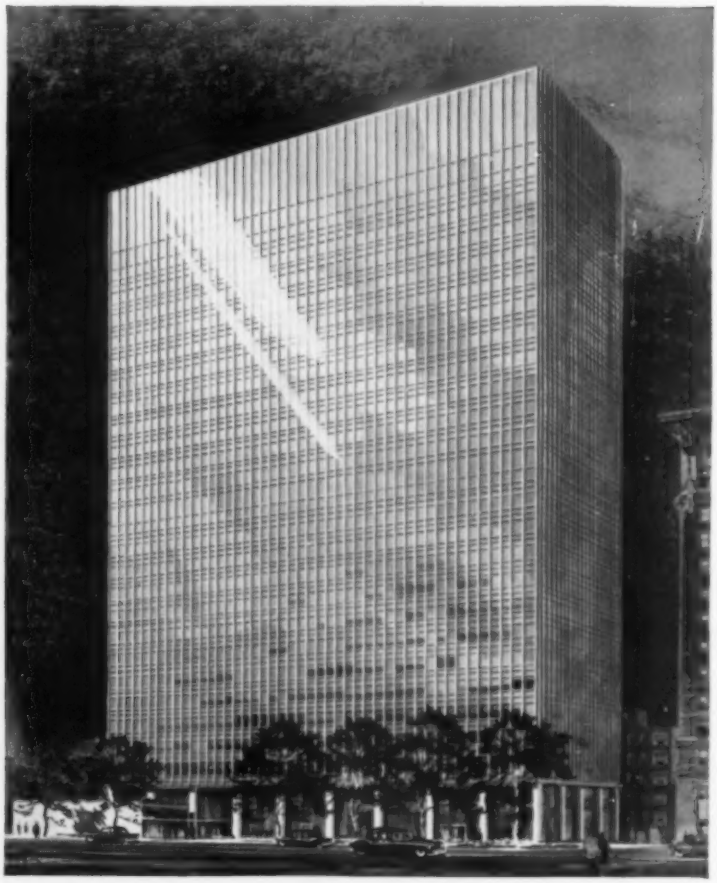
McGEORGE & HARGER
mechanical engineers

GEORGE A. FULLER COMPANY
general contractor

GORMAN LAVELLE COMPANY
plumbing contractor

AMSTAN DIVISION,
AMERICAN RADIATOR
& STANDARD SANITARY CORP.
plumbing wholesaler

AMERICAN RADIATOR
& STANDARD SANITARY CORP.
fixture manufacturer



Cleveland's New Skyscraper is

THE TALK OF THE TOWN

The 22-story, $17-million ILLUMINATING BUILDING, Cleveland, Ohio, is an impressive architectural achievement in exterior beauty and interior efficiency. The glass and metal facades enclose 400,000 square feet of completely air conditioned office space surrounding a functional center core which houses 10 high-speed automatic passenger elevators, a freight elevator, stairways, washroom facilities, air conditioning ducts and related equipment. The unobstructed floor areas make possible the most efficient office layouts. In addition to natural light, a fluorescent light system provides a high level of balanced illumination throughout the building. All windows are sealed and are washed on the outside from an electrically controlled, vertically traveling stage. As are thousands of other expertly planned buildings, the new ILLUMINATING BUILDING—Cleveland's new, third largest office structure—is completely equipped with SLOAN *Flush* VALVES.

SLOAN *Flush* VALVES

FAMOUS FOR EFFICIENCY, DURABILITY, ECONOMY

SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive folder

wire from Washington

TWO MAJOR HEALTH ISSUES

Two issues in the hospital field are getting attention in Congress even though economic problems, space-age science and old-fashioned politics dominate the scene. The two issues, involving health services close to the people, naturally have their own political potential.

One of the questions has to be decided before adjournment, and probably will be settled in the next month or so. That is, how much money will be voted to the Hill-Burton hospital construction program? Will it be cut back sharply as recommended by President Eisenhower, carried along at about its present level, or increased?

The other issue involves improving the lot of the older people, more particularly how to give them more and better nursing home care and how to finance their hospital and medical care.

HILL-BURTON APPROPRIATIONS

On Hill-Burton appropriations, there is only the slightest possibility that Congress will accept the deep cuts recommended by the President. On January 13 Mr. Eisenhower's budget message, proposing $75 million rather than this year's $121.2 million, went to Congress.

Routinely, the Hill-Burton section was referred to the House appropriations subcommittee headed by Rep. John Fogarty (D-R.I.). It had hardly reached the subcommittee before wires and letters started arriving. By mid-February, even before Mr. Fogarty had reached the H.-B. items, he had heard from every state in the union and from almost every large city.

In virtually all of the messages, the appeal was the same: The Hill-Burton hospital construction program has proved itself; if its funds are drastically cut back now, hospital construction will never recover the momentum that has been built up in the last 10 years.

Friends of the Hill-Burton program are convinced that unless a realistic appropriation is voted, scores of communities all over the country will feel they have been let down by the federal government. These are the towns and cities where fund drives are now under way for new hospitals, in anticipation of federal help. Because they have received no actual commitment from state H.-B. authorities, but just an informal go-ahead signal, there would be nothing these communities could do but fold up their money campaigns and wait. The fear is that many of them would be reluctant to again plunge into public fund raising and negotiations with banks even if a few years later they should be told for a second time that U.S. money is in sight.

But the prospects are that this situation won't be allowed to develop.

Judging from its record, the Fogarty subcommittee can be expected to add between $25 and $50 million to the figure set by the President, to win approval of the full committee for the increase, and to push the higher figure through the House. Rep. Fogarty's personal interest in Hill-Burton was indicated last month when he sent a letter to President Eisenhower asking for a revision of the budget which would authorize the full amount of $210,000,000 for Hill-Burton next year, as an anti-recession move. Rep. Fogarty has also authored a bill which would provide long-term loans, at little or no interest, to finance hospital renovation programs. In the Senate, Chairman Lister Hill (D.-Ala.) of the companion appropriations subcommittee will be ready to throw his support behind any House increase.

At the subcommittee hearings a parade of witnesses, headed by spokesmen for American Hospital Association, argued for increases in the Hill-Burton funds. Almost alone in backing the President's lower figure were representatives of the Department of Health, Education, and Welfare, U.S. Public Health Service, and the Budget Bureau. It can be assumed that the H.E.W. and P.H.S. witnesses acted out of administrative responsibility, and not because they wanted the program cut back. But the Budget Bureau people, who insisted on the cut in the first place, put up a strong argument for holding the line in keeping with the White House policy of economy in civilian activities. (While these hearings are "executive," or secret, how the various witnesses line up is never a mystery for long.)

HEALTH FACILITIES FOR AGED

Extension of the H.-B. program this year—it is scheduled to expire June 30, 1959—is closely involved with the major issue of what to do to help the older people.

In his budget message, Mr. Eisenhower said progress already had been made toward meeting community requirements for general beds, and that when the program is extended it should be restricted to meet "only the most urgent needs, with emphasis on specialized needs."

While there was no elaboration, it is obvious the White House wants more emphasis on the "categories"—diagnostic-treatment centers, nursing homes, chronic disease hospitals, and rehabilitation centers.

Congressional health leaders are not inclined to cut off funds for general hospitals—one told The Modern Hospital, "That is still the greatest need"—but a move is building up within Congress and on the outside for a nationwide experiment, subsidized by U.S. grants and mortgage guarantees, for nursing homes that would be attached to hospitals or have their own medical services.

Such institutions, if established on a broad geographic pattern, would help to solve one of the problems of the aged. They would offer the old people institutional care at a cost far less than hospitals have to charge. At the same time doctors and nurses would be readily available when needed. One suggestion is for $50 million for grants to nonprofit homes, and guarantee of low-interest, long-term mortgages for proprietary homes.

For this new plan to succeed, its sponsors point out, nonprofit and commercial insurance companies would

have to approve payment of bills for aged patients in this new type of nursing home.

FORAND BILL

Because of pressure of other business, the House ways and means committee hasn't yet taken up the controversial Forand Bill, under which social security would pay hospital and nursing home costs of the aged and their dependents. If the committee can dispose of the bill for extending reciprocal trade treaties in time, then finish its work on the tax bill, hearings on the Forand Bill could come in late March or early April. But any emergency development would mean still more delay, and possibly no action whatever on the Forand Bill.

Meanwhile, organized labor is not taking any chances. George Meany, A.F.L.-C.I.O. president, has addressed a letter to many congressmen on the Forand Bill. It points out that the American Medical Association is campaigning vigorously against the bill, and urges the congressmen not to swallow the A.M.A arguments without first taking a look at the other side—the "practical need for this legislation."

If a decision is postponed on Forand, its chances of passage in the Senate will be far greater next year than this. Decision of Sen. Harry F. Byrd (D.-Va.) not to run for reelection this year will turn over chairmanship of the Senate finance committee to Sen. Robert F. Kerr (D.-Okla.). They are perhaps the two richest men in the Senate—Byrd, apples; Kerr, oil—but there is hardly another similarity that can be detected.

If the Forand Bill reached the Senate this session—it would have to pass the House first—Byrd, conservative and economy-minded, would delay the bill in committee, hoping time would run out. Kerr, a staunch "fair dealer," would get it through the committee and on the floor as fast as he could.

NOTES

A House subcommittee hearing on tranquilizers didn't develop the information the lawmakers wanted, at least not on the opening days. Four of five witnesses, all physicians, said the pharmaceutical houses putting out the drugs were all careful in production and testing and their advertising was not misleading. Another story might be heard from a group scheduled to testify at a later hearing.

Dr. Russell R. Morgan of Johns Hopkins heads a new P.H.S. committee appointed to advise the agency in its work on radiation.

Senator Thye (R.-Minn.), telling of reports from a visitor to Russia, says a Russian university professor in U.S.S.R. will on the average receive from four to six times as much income as a physician.

Group Health Federation, speaking for lay-sponsored, prepayment medical and hospital care plans, is asking Congress to give these organizations' hospitals the same tax status as other hospitals. Because they are classified as "social welfare" organizations for tax purposes, gifts to them are not tax deductible. Other types of nonprofit hospitals are classified as "charitable," giving them a "first class exemption" status.

Veterans Administration has under way hospital construction projects that will cost between $16.9 million and $23 million (estimated range of bids). Improvements or additions are scheduled for hospitals at Syracuse, N. Y.; Newington, Conn.; the Bronx; Ann Arbor, Mich.; Bedford, Mass.; Chillicothe, Ohio; Roanoke, Va., and Downey, Ill.

A special committee that investigated national stockpile problems recommended, among other things, that producers and distributors of hospital, medical and pharmaceutical equipment should be "encouraged" to maintain larger inventories and to keep them dispersed in the interest of national defense and survival under enemy attack. The committee, reporting to the Office of Defense Mobilization, did not suggest any specific ways in which the U.S. could stimulate or subsidize such operations.

Several Democrats in Congress have offered their own bill for federal scholarships to stimulate development of scientists and mathematicians. In contrast to the Eisenhower plan to spend $1 billion dollars over four years, their idea is to spend $3 billion over six years. Also, they would provide 60,000 scholarships, in contrast to the Administration's 10,000. Because the Democrats' scholarships would extend six years, a student would be eligible for help during four years of pre-med work and two years in medical school, provided he did not take a degree at the end of his first four years. Under both bills fellowships presumably would be a source of trained manpower for medical school faculties.

Chairman Olin Teague (D.-Tex.) of the House veterans affairs committee would tie up Veterans Administration in this manner: V.A. could not close out any hospital or other medical facility without giving the committee 90 days' notice. Furthermore, if a congressional session ended before expiration of the 90 days, the notification period would start all over again when the next session began. This would mean, in effect, that notification of closing could be given only in the period January-April. No hearings have been scheduled on the Teague Bill.

The long-stalled bill for pay increases for medical personnel in Veterans Administration now seems to have gotten off the ground. The House veterans affairs committee has adopted the Administration's bill, after making some changes. Most important amendments would increase the bonus for specialists from 10 per cent to 17.5 per cent; under present law it is 25 per cent. Under this bill optometrists are classified with auxiliary medical personnel, not with physicians and dentists.

Under a new Medicare interpretation, if the doctor orders a private room the patient pays 25 per cent of the difference in cost between it and the weighted average of semiprivate care. But if the patient or sponsor insists on private care, and the doctor doesn't, the patient pays the full difference.

Another Medicare ruling entitles nurse anesthetists and physical therapists who work on an independent basis to direct payment, if the attending physician specifies their services and if the fee is a "normal charge" for persons with an income of $4500 or less.

Outlining their legislative programs before the House veterans affairs committee, spokesmen for the Disabled American Veterans and the Veterans of Foreign Wars took relatively moderate stands. The D.A.V. representative, in fact, said his organization would not work for legislation to increase the benefits for nonservice cases.

Office of Defense Mobilization has released a list of items that might be needed to sustain the population after a nuclear attack. Included are specific pharmaceuticals, blood collecting and dispensing supplies, biologicals, surgical textiles, emergency surgical instruments and supplies, and common use medical and hospital items. It is available from O.D.M, Washington, D.C.

The Modern Hospital
MARCH 1958

Delegates to the A.C.H.A.'s first educational congress crowd both the main floor and balcony of the hotel ballroom at the opening general session last month.

MANAGEMENT STRESSED AT A.C.H.A. CONGRESS

CHICAGO. – The American College of Hospital Administrators observed its silver anniversary by holding the First Congress on Administration here February 9 to 11. Somehow, Executive Director Dean Conley explained, an educational congress seemed to be a more fitting way to celebrate than "putting a lighted block of ice on the banquet table."

Apparently a large segment of the college membership thought so, too. Nearly 900 persons jammed the 25 breakfast-meeting seminars to hear how other administrators solve their management problems, and listened earnestly to four speakers at the general sessions who soared into the rarefied atmosphere of scientific management, behavioral problems, operations research, and—inevitably—automation.

Although the speakers were duly applauded for their contributions, it was the seminars that the college members seemed to enjoy most. There, they could plant their elbows firmly in their neighbors' coffee cups and wrangle about such day-to-day concerns as getting committees to arrive at a decision; where line and staff officers' duties conflict and how to keep them from fighting; how to conduct interviews with subordinates, superiors and peers; the importance of long-range planning; the rôle of the board of trustees, and how to select executive talent.

The theme of the session on "Line *vs.* Staff Accountability" was that the concept that the staff man can only function in an advisory capacity is both frustrating and uneconomical. The staff officer's principal function is considered advisory and informative, the panel decided, and in a small institution there may not be any such person. When there is, he is to be found in the personnel, purchasing, public relations, and methods engineering departments. His conflict with the line officers, *i.e.* the department heads, usually stems from a difference in temperament and the fact that he is interested in ideas and activities rather than day-to-day results. The department head is likely to consider him impractical and a "long-hair." Since the number of staff officers is increasing, however,

A.H.A. Midyear Delegates Hear Reports on Counseling, Infections, Problems of Aged

CHICAGO.—The American Hospital Association gave its annual progress of projects report to the Midyear Conference of Presidents and Secretaries of State and Regional Hospital Associations here February 7 and 8.

High on the agenda was Dr. Madison Brown's review of the hospital counseling service, financed by an $850,000 Ford Foundation grant that will underwrite the service for five years. The purpose of the service will be to make administrative surveys of institutions that request such assistance "to attempt to evaluate the adequacy and efficiency of the administration." There is no thought on the part of the A.H.A., Dr. Brown explained, of establishing another set of standards, as some people seemed to fear, or of overlapping with the functions of the Joint Commission on the Accreditation of Hospitals. Nor, he asserted in answer to a question, will the counseling service tread on the toes of professional consultants. Actually, it should open up the field for full-time consultants, he believes.

The initial staff for the service has been selected, Dr. Brown said, and when the procedure for conducting the surveys has been finally decided, the initial surveys will be made—probably in the last quarter of 1958. In addition to the central headquarters staff, five field consultants will be employed. Service will be given on the basis of urgency of need and will be available free to listed hospitals during the five-year period of underwriting. Proprietary hospitals which are

(*Continued on Page* 140)

the panel decided that it is essential to remove as many sources of conflict and jealousy as possible. Two ways to do this, it was suggested, are to hold the staff people equally accountable with the department heads for the results of their activities—whether they are good or bad; and to give full credit and recognition to both when their joint efforts have produced a successful result.

A special kind of staff officer, the "assistant to" the administrator, came in for a thorough going-over at a seminar devoted to the dissection of this species. If there were any "assistants to" in the room, they probably wished they were somewhere else. In general, it was agreed by the panel members that the individual takes his position from, as one of them phrased it, "the person to whom he is assistant to," that his position is nebulous and without authority in its own right, that he should not have more recognition than the assistant administrator who actually carries the burden of responsibility for daily hospital operation. Although, ideally, the assistant to the administrator should be an extension of the administrator himself and should serve as his eyes and ears, he may find himself regarded as a spy and informer. He is further handicapped, various speakers pointed out, by not knowing from day to day just what his job is. It was the consensus of the group that most "assistants to" are likely to end up seeking a job that gives them personal status in the organization.

Although hospitals have looked to industry for guidance in the selection of executives, a speaker at the panel on this subject pointed out, industry hasn't done so well in this direction itself. "After all," said Norman Kaye, administrator of Saratoga Hospital, Saratoga Springs, N.Y., "hospitals at least select their own executives; the executives don't inherit their jobs from their fathers the way they do in industry."

The usual indications of noble character, such as honesty, loyalty, integrity and so on, recited by various panelists as basic to the selection of the executive, were challenged by a speaker who stated dryly that they reminded him of his mother—a fine person possessed of all these lofty traits but "absolutely the world's worst executive." The lofty traits are needed, he agreed, but they aren't enough. An executive also has to have drive, energy, initiative and a willingness to accept responsibility, he maintained.

Long-range planning and how long the range should be apparently are a matter of concern to many of the people attending the congress. The largest meeting room was filled with administrators seeking the answers to this problem. The thesis of the session was summed up briskly by the seminar leader, Dr. T. Stewart Hamilton of Hartford, Conn., as "plan or perish." He backed up his argument by pointing to various industries that have perished for lack of foresight and planning.

In answer to the query: How long is long range? panelists agreed that the range should be no less than five years and probably between 10 and 15. However, plans should be kept flexible to permit of change and they should be reviewed periodically to be sure that the long-range plan still meets the needs of the hospital and community. It was recommended that the architect should be brought in on the original planning sessions so that he will know what the ideas and desires of the hospital personnel are.

The size of the site for a new hospital can be determined only by a survey of the community needs and population trends. What types of people does the hospital serve? Young or old? How many maternity cases are there likely to be? How many aged patients? Are new industries coming into the community or is it going down hill? The speakers agreed that all these factors must be thought about. One person suggested that in an area where land is available, the hospital should have approximately

(*Continued on Page* 144)

Dwindling Number of Ward Patients Causes Concern for Intern and Residency Programs

CHICAGO.—The steadily dwindling number of ward patients in teaching hospitals is the chief concern of graduate medical education today, it was apparent here last month at the 54th annual Congress on Medical Education and Licensure.

Interns and residents, especially in surgery and the surgical specialties, must accept some direct responsibility in the care of patients in order to have a meaningful educational experience, it was emphasized repeatedly during the Congress, yet with fewer and fewer ward patients in hospitals, opportunities for taking responsibility are limited.

Obviously, it was explained, private patients will have to be used increasingly in teaching programs—at the risk of displeasing the patient if he knows what is going on, and defrauding him if he doesn't.

Summarizing the problem at a conference on specialty training, Dr. T. Stewart Hamilton, executive director of the Hartford Hospital, Hartford, Conn., reported the case of a patient who sued the surgeons, charging assault and abandonment, when she learned that her operation had been performed by the resident and not by the attending surgeon, as she had supposed—even though the result of the operation was perfectly satisfactory.

Every one of some 30 colleagues with whom he had communicated about the problem responded that private patients would have to be used in teaching programs, Dr. Hamilton reported. If they are approached in the right way most patients will cooperate, he added.

Analyzing the residency problem further, Dr. Allan C. Barnes, chairman of the department of obstetrics and gynecology at Western Reserve University School of Medicine, Cleveland, said that without a real transfer of responsibility for patient care to the resident, "we will train a group of accomplished technicians who will have been ghosted to technical aptitude, but we shall not have trained surgeons and gynecologists."

Plans to remedy the situation by having residents take part of their training in smaller, affiliated hospitals —following the movement of population from urban to suburban and exurban areas—were described as unsatisfactory by Dr. Barnes, who called this kind of training "a mixture of residency and preceptorship." Usually, he said, the men in the smaller, outlying hospitals are not primarily interested in teaching—"or they wouldn't be there," he added.

Another proposal—to affiliate residents with group practice clinics—also presented some problems, Dr. Barnes pointed out, since they would then be in competition with private practitioners, who might object, and since most Blue Shield plans and other insurance companies do not provide payments to residents for services they render to patients covered under the plans.

The insurance problem will have to be worked out so that residents can be paid for their services, and the medical practice acts must be revived to support the use of private patients in teaching programs, Dr. Barnes concluded. He also asked that American Medical Association policies be adjusted to conform with the existing situation in medical education.

In an address at the annual meeting of the Federation of State Medical Boards, which sponsors the Congress jointly with the Council on Medical Education and Hospitals of

(*Continued on Page* 138)

What to Do About Hospital Infections

The first thing, leading hospital and health authorities point out, is to recognize that the problem exists and that ignoring or concealing an outbreak of staphylococcus infection is not the way to combat it. Suggested measures are: establishment of an infections committee of the medical staff charged with the responsibility for investigating all reports of infections, and general tightening up on the observance of aseptic technics.

JANE BARTON

HOSPITAL administrators and doctors who have hoped that if they just ignored or refused to discuss staphylococcus infections (officially known as Micrococcus pyogenes var. aureus) in their hospitals, the offending organisms would go quietly away and no one would be the wiser can now take their heads out of the sand and face the fact that they have a problem, that everybody knows it, and that help in controlling the infections is available for the asking.

They can take comfort, too, from the knowledge that they are not alone in their trouble. The ubiquitous Staphylococcus, refusing to stay decently buried by the antibiotics, has been invading hospitals all over the United States and in England, Canada and Australia for the past several years and has been the subject of many frank and carefully documented articles in medical and public health journals dating back to the 1940's.

NO DATA ON GENERAL HOSPITALS

However, in a study of infections at King County Hospital, Seattle, presented in the *Journal of the A.M.A.* last August, Drs. Donald N. Wysham and William M. M. Kirby were still able to state that: "Though specific types of micrococcic infection have been reported, there is no current description in medical literature of the scope of the problem *in a general hospital*. Information is not available concerning the approximate incidence of such infections, nor is a description of the types of infections commonly encountered and their severity. Such data are valuable in order to provide perspective to the problem, to stimulate investigation of various means of control, and to permit evaluation of preventive measures."

If individual hospital administrators and physicians are shy about mentioning the "Staph. problem" in polite society, the national hospital and medical associations and public health officials, fortunately, are not.

A committee on infections in hospitals of the American Hospital Association has as a primary objective the establishment in every hospital of a standing committee on infections analogous to the tissue committee. The infections committee, backed by the laboratory service and supported by the whole staff (it is hoped), would study all reports of infections and report to the medical staff. Studies revealing which doctors persistently had high infection rates are expected to have a salutary effect on the offenders. Some members of the A.H.A. committee think an ultimate goal should be to make the "infections committee" a requirement for accreditation as the tissue committee now is.

One reason doctors and administrators are reluctant to make their difficulties known, it has been pointed out, is that epidemics give them a feeling of guilt and an understandable fear of unfavorable publicity. An epidemic implies negligence, a break in aseptic technic, a lack of plain everyday cleanliness—and what hospital wants to own up to such sins? Again, tracking down the causative agent, determining who or what the carrier is, and discovering how far the infection has spread both in and out of the hospital are difficult tasks.

Furthermore, some delicate interpersonal relationships and administrative problems are involved. Investigators have reported, for example, that in some cases of surgical wound infections the nurses have been quite aware of what was going on but were afraid to report to the administrator for fear of getting into trouble. In another instance, the difficulty concerned the use of nursing personnel. The nursery supervisor in this hospital was outraged because not only were her nurses shifted out of the nursery and sent to other floors that were short of help—they were being sent to the emergency department and the pediatrics floor where there were known to be staphylococcus infections which would inevitably be transmitted back to the infants when the nurses returned to the nursery. To her it made no sense at all but, because of the nursing shortage, the administration had felt helpless to remedy the situation.

ACCREDITATION REQUIREMENT

At the A.H.A.'s midyear conference for presidents and secretaries, Dr. Kenneth Babcock of the Joint Commission on the Accreditation of Hospitals announced that the March Bulletin of the Commission would contain a recommendation that all hospitals establish committees on infections and that by September or October it is expected that such committees will be made mandatory for accreditation.

OUTSIDER CAN HELP

Problems like these can only be solved by the individual hospital, but often expert advice from an impartial outside agency is invaluable both in determining the cause of the trouble and in pointing out poor practices and hazards that have grown up in the hospital through long usage and inanition. Such expert advice is available to any hospital from state departments of health to which all epidemics, or suspected epidemics, should be reported. Most state health departments have the trained personnel and facilities necessary to track down elusive organisms and suggest remedial measures. Where the situation warrants it, they can, and often do, request additional help of the Public Health Service's Communicable Disease Center at Atlanta, Ga., both

from its Epidemic Intelligence Service and from its extensive diagnostic laboratories.

Although the C.D.C.'s epidemiologists enter a case only upon invitation from the state health department, once they are called in they work happily and indefatigably with state health officers and hospital staffs to clear up the infection and prevent a recurrence. It is a source of bafflement and distress to Communicable Disease Center officials that hospitals don't make better and more frequent use of the state health facilities.

By way of explaining how the Epidemic Intelligence Service works, Dr. Walter Murray, assistant chief of the surveillance section, discussed the procedures followed, and the problems encountered, in two outbreaks: one a nursery epidemic in the South and the other a sudden rise in the incidence of wound infections in an eastern hospital.

NURSERY EPIDEMIC

On invitation from the state health officer, Dr. Murray and Jennie Rakich, R.N., assistant chief of the nursing section, assisted in the investigation of an outbreak of breast abscesses and impetigo among infants, which had first been reported by the hospital's chief of staff. Their initial efforts were directed at determining what type of epidemic it was: (1) the short, sharp variety, probably caused by a single carrier suffering from a carbuncle or upper respiratory disease; (2) multiple phage type spread by poor aseptic technic on the part of several individuals, or (3) one dominant phage type spread by more than one permanent or temporary carrier.

Bacteriophages are considered to be viruses which parasitize bacteria. They exhibit a strong host specificity, which is so fixed that it is possible to identify a particular strain of bacteria by identifying its specific bacteriophage. This is done by seeding a plate of culture medium with the organism to be tested, then systematically placing a small drop of each specific type of phage on the culture. The culture is then incubated. If phages are used that are specific for the organism being tested, the organism will be dissolved by the phage, leaving a clear area on the culture plate. Most organisms are susceptible to several phages so that the phage type is determined by the pattern of lysis produced.

What looked like a "hot" lead turned up when it was discovered that a nursery aide had been on duty while she was suffering from an underarm boil. Nobody had been aware of it until she was admitted for treatment, and she had since left.

In the course of their survey the investigators checked the census of the nursery and the length of stay; observed handwashing technics, methods of autoclaving linens and rubber goods, and cleaning procedures; studied the ventilation system to see whether infectious organisms were being carried into the nursery from other areas, and reviewed the laboratory books to see if cultures taken had shown any definite pattern of infection. Charts of the nursery workers were pulled to determine what cultures had been made and whether antibiotics had been given. Dr. Murray and Miss Rakich were disappointed because the cultures which had been made had been thrown away and therefore couldn't be carried out to the final diagnosis since the material needed for phage typing (necessary to isolate the causative organism) was not available. One recommendation that epidemiologists have for all hospitals is: "Keep all cultures for at least three months. You never know when they will be needed."

Hospital records showed infections in 15 infants and one mother and, at a meeting with the pediatric and obstetric staffs, the C.D.C. team obtained permission to make a telephone survey of mothers who had delivered the preceding month to find out how many infants—or mothers—had developed infection since their discharge from the hospital.

The telephone survey, introduced by Dr. Reimert T. Ravenholt of Seattle, has proved to be a useful case-finding tool. One of the problems in determining the extent of an epidemic is that infection picked up in the hospital may not develop for days or weeks after discharge. When an epidemic does appear in a nursery, epidemiologists assume that a certain proportion of infants and mothers who have been discharged will also show infection sooner or later. In this case, a check of 49 mothers revealed that some cases of impetigo and breast abscesses had developed. Unless patients are readmitted to the hospital for treatment in such instances or individual staff members report cases of infection among their patients, a hospital may remain blissfully unaware that it is sending infected cases out into the community.

The telephone survey is carefully phrased to elicit from the mother all necessary information about any symptoms she or the baby has developed without making her aware that the inquiry is more than a routine health department check. Investigators have found that the mothers are very cooperative and that their reports are reliable. It is essential, of course, to have the approval of the physicians before such a survey is undertaken.

Some of the remedial measures Dr. Murray and Miss Rakich suggested after studying the hospital's procedures included: autoclaving of linens by individual packs for each baby instead of in one big batch; more frequent checks on the autoclave to be sure it is in working order, and tightening up of handwashing practices. In this hospital there were no written standards regarding handwashing and Miss Rakich urged that such standards should be put in writing as a part of the procedure manual. Another problem was the location of the sink at one end of the nursery so that nurses had to do a lot of traveling in order to comply with handwashing requirements.

On the basis of this and other studies, Dr. Murray believes that mothers and infants should be discharged as early as possible, pointing out that if staphylococcus already exists in the nursery, the longer an infant stays, the more likely he is to pick up infection. He believes that newborn infants are rapidly infected by older ones and, especially if the nursery census is high, the danger of contamination from droplet nuclei, dust and lint particles is enhanced. He is in favor of rooming-in as a control measure or, where this cannot be effected, of separating the infants according to the day of birth either in separate small rooms or by means of partitions. Dr. Murray's idea, which he shares with other epidemiologists, would be that each room or section should accommodate a few infants (perhaps four or six) of the same age; the rooms would be filled in rotation and would be emptied as each group is discharged from the hospital. As each room is emptied it should be thoroughly cleaned and left untenanted for a couple of days to allow organisms to dry out completely.

CARRIERS HARD TO TRACE

The most vital step in wiping out an infection is to detect and remove the carrier. Unfortunately, this is also extremely difficult of achievement and the source of a good many debates. Since a large segment of the population carries some strain of staphylococcus, either permanently or transitorily, it is obviously unsound to remove from an infected area everyone who shows staphylococci on a routine culture. Most of the strains are quite harmless and, as bacteriologists have pointed out, may well serve as a protection against the virulent organisms. In order to be meaningful, cultures must be tested both for sensitivity to various antibiotics and for the precise

MEDICAL AUTHORITIES RECOMMEND WAYS TO CURB INFECTIONS

NURSERY EPIDEMICS

1. Close the nursery, wash the walls, transfer the infants to another room.
2. Discharge all infants and mothers as soon as possible after delivery—24 to 48 hours, if practicable.
3. In an epidemic situation advise the mothers of the risk entailed in breast feeding at these times and curtail breast feeding as much as possible.
4. Make maximal use of "rooming in."
5. Again reemphasize the never ending police job of encouraging proper handwashing between the care of each baby.
6. Persistent nasal carriers should be recognized and removed from nursery duty.
7. Some authorities recommend daily washing of the infants with hexachlorophene solution, pending the results of further investigations.

OPERATING ROOM INFECTIONS

How to Prevent Introduction of Infection:

1. Prevent entrance of "dirty" cases into major operating room.
2. Require anyone entering to wear scrub suit; scrub dress to be covered with sterile gauze. Cover shoes worn in operating room with muslin covers provided.
3. Consider eliminating all unnecessary entries into operating room. Study of movements of operating room personnel should lead to reduction of movements as far as possible.
4. Keep all doors closed and curtail number of entries during operation.
5. Investigate the possibility of installing floor exhaust outlets and a plenum ventilating system for both heated and cooled air that would give fresh outside air changes at rate of eight to 12 changes per hour. The exhausts should remove only from two-thirds to three-quarters of air so positive pressure would move dust out through leaks or opened doors.
6. Keep patient's bed and blanket (particularly if blanket is wool) out of operating room.
7. Do not permit members of staff with upper respiratory infections and staphylococcic lesions to work.
8. Transfer patient to table gently and with minimum of movement. If anesthesia room is available, transfer should take place there.
9. Reduce unnecessary equipment in operating room, e.g. lockers, oxygen hose.
10. Use best quality gloves and be alert to detect punctures.
11. British authorities recommend that if impervious masks (cellophane layers) are not available, double masks should be worn, with changes of outer masks by circulating nurse during long operations (45-60 minute intervals).
12. Make anterior nasal cultures of members of operating room staff at intervals to help regulate problem of permanent carriers.

How to Prevent Cross Infection:

1. Isolate patients as soon as suspected of wound infection on clinical grounds. Separate personnel, using isolation technics, would be ideal. When this is impractical, isolate wound by impermeable occlusive dressings, masks and sterile gloves.
2. For woolen blankets, use quaternary ammonia compound before final rinse in laundry.
3. Discontinue prophylactic antibiotics. The building of resistant selective breeding strains of organisms is to be discouraged. Recent English literature describes delay in healing when penicillin is given to patient with penicillin-resistant staphylococcal infection.
4. Be gentle in the movement of linens while making beds, particularly in areas where wound dressing is in progress. Avoid cross transfer of linens, particularly blankets.
5. Wash hands after contamination and before handling the environment of new patients.
6. Consider need for careful washing of doctors' and assistants' hands before changing dressings, and use of gloves and masks.
7. Obtain advice on changes in dressing truck technics from the American College of Surgeons. In general, special septic sets containing necessary instruments and dressings autoclaved in paper covering, or paper bag for disposal of removed dressings, should be considered.

strain of the organism found. Phage typing, which is the means of isolating the various strains, is a job few hospital laboratories are equipped to carry out. Cultures have to be sent to a laboratory that can make the tests. And here the state health departments can be helpful by advising local hospitals where phage tests can be made.

A question that always arises when infection appears is whether antibiotics should be administered routinely to personnel on duty in the affected area. The answer of most public health authorities is "Certainly not on an empirical basis." Such a procedure is a waste of time and money unless the organisms have been typed and sensitivity tests have been made, and it raises the hazard that virulent strains resistant to antibiotics may take over.

Carriers of virulent strains can be very difficult to catch up with, as Dr. Murray and his co-workers have learned to their sorrow. In one situation, he related, the epidemiologists thought they had tested every person who might have even a remote connection with the outbreak and still were unable to find a culprit. Then, quite unexpectedly, they ran across a person they had never seen in the hospital before and questioned her. It turned out that she actually was the carrier but, because she worked only one day a week, nobody on the hospital staff had given her a thought. At the southern hospital studied, the nurse's aide with the boil was an obvious suspect—and she had already removed herself—but, until she could be found and examined, nobody could be sure she was the cause of the nursery epidemic.

A problem that vexed Dr. Murray considerably was whether moving the infants out of the nursery to another area would be particularly helpful as long as the same staff went along. If one of this group were a carrier, he argued, wouldn't she just carry the infection to the new nursery? Might as well leave the infants where they were. The ideal situation, of course, would be to move the babies to an uncontaminated section and staff the nursery with a new group which had been proved free of infection.

Finally, even after sensitivity and phage tests have been made, and specific organisms have been isolated, still another hazard remains. Dr. Elaine L. Updyke, bacteriologist at the Communicable Disease Section, is concerned lest the publicity given to the strain known as Phage Type 52/42B/81 may make hospitals careless about other strains that may be equally vicious but aren't as well known. "If they get a report that 52/42B/81 has been found, they may get all excited and think: We've got a problem here, whereas the strain may not be the cause of the outbreak at all," she explains. "And on the other hand, if some other strain shows up, the hospital people may feel that it is nothing to worry about when actually it is."

SURGICAL WOUND INFECTIONS

The C.D.C. investigation into the outbreak of postoperative wound infections at the eastern hospital came as a result of a call for help to state health officials from the hospital administrator and pathologist. They were alarmed by the discovery of

15 wound abscesses occurring after "clean" major operations; 14 of these operations had taken place in the major operating room and one in the minor operating room. It later developed that the patient who had been in the minor operating room was in the habit of visiting other patients and could have picked up the infection from one of them.

This epidemic appeared to be of the short sharp variety, stemming from one of two possible sources (or perhaps both) but, here again, the epidemiologists were handicapped by lack of cultures to test for accurate determination of the particular strain. The pathologist had taken three swabs from infected wounds, all growing pure cultures of micrococcus. However, none of them had been saved; nor had cultures taken from the noses and throats of operating room personnel, three of which were positive for hemolytic Micrococcus aureus. At the request of the public health officials, it was agreed that all further cultures taken would be forwarded to the state health department for verification of the diagnosis.

Before the public health officials arrived at the hospital, certain remedial measures had already been undertaken as a result of a conference with medical staff members and on the recommendation of an outside consultant. These included: culture survey of the operating room personnel and removal of those who showed positive cultures; installation of a door between the major operating room and the autoclave room; orders to keep the doors to the operating room closed at all times; the manufacture of muslin or stockinet boots to cover street shoes; long coats or gowns for anesthetists; use of special rubber mops for wet-mopping walls as well as floors between operations; lowering of rubber oxygen lines for easier dusting; overhauling of autoclaves; installation of screens; purchase of additional dressing carts, and closing of the operating room for repainting.

Since the operating room had been repainted the day before they arrived, the investigators did not consider an environmental check at that time necessary. However, they were concerned over the continued use of a broken air conditioner which they believed was quite probably carrying infectious organisms between the operating room and the autoclave area and adjacent central supply room.

In his summary of the investigation Dr. Murray hypothesized that the original carrier could have been either a physician, present at all of the 14 major operations, who had been reported guilty of breaking aseptic technics on several occasions, or a badly infected burn case brought up to the operating room for a grafting operation on his own bed with its (probably infected) blankets still on it who might well have seeded the entire area. He noted also that "indiscriminate prophylactic" use of antibiotics in this hospital was "appalling."

The report concluded: "A favorable environment for passage and persistence of the infection was encountered. Poor technics, a broken air conditioner still in use, and steam radiator at table height could very well have created currents of dust blowing into the operating field. And the open doorway between the operating room and the autoclaves may have accentuated the problem."

A summary of the recommendations made by various authorities for the prevention of infection both in the nursery and in postoperative infections is shown on page 53.

CONCLUSIONS

Dr. Robert J. Anderson, chief of the Communicable Disease Center, would have no one think that public health officials, either state or federal, believe they have "all the answers." Rather, he pointed out, their ideas are subject to constant review and revision as new studies reveal new information. What they do have, in addition to long experience and talented laboratory workers skilled in technics that are beyond reach of many hospital laboratories, is an earnest desire to help the hospitals to the full extent their facilities and personnel will permit.

Like other hospital and medical authorities, the Public Health Service epidemiologists are willing to state categorically that hospitals must clean up and tighten up on the observance of aseptic practices. Obviously, they can no longer rely on the antibiotics to do the job for them. Over-usage of antibiotics has already turned and bitten them and may bite harder in the future if and when more micrococcal organisms develop resistance to more antibiotics.

In his report on the postoperative wound infections, Dr. Murray pointed out the "serious economic loss to patients and the hospital reflected by 15 cases having used 313 hospital bed days, an average of 20.9 days." If enough patients are forced to stay in hospitals for long periods as a result of hospital-engendered infections some nasty questions are likely to be raised by insurance carriers and by the patients themselves—or their lawyers. One official queried on this point stated that "if a jury ever saw pictures of a patient with three or four drain incisions following deep breast abscesses, it might well consider the case compensable."

The idea is spreading fast that hospitals should stop worrying about concealing the evidence of epidemics and concentrate on preventing them.

Good Housekeeping Reduces Infections

SALLY HEITMAN

INFECTION is an ever present danger in any hospital and it is essential that executive housekeepers, who are responsible for maintaining the cleanliness and safety of the institution, understand the hazards and how to combat them. Let us look at the immediate environment of the patient. What reservoirs of infections does he encounter?

PATIENT AREAS

The bed.—The patient lies on a mattress, sheets and pillows and is covered with a sheet, blankets and spread. Suppose he has an upper respiratory infection or a draining wound. Infection material can get on his hands and be transmitted to the linens, the mattress or the pillows. Possibly he has a paper bag fastened to the side of his bed in which to place used tissue wipes. These may land on the floor or the bag may become saturated and, in turn, penetrate the mattress. If the linen is contaminated it may, in turn, contaminate the underside of the mattress by being tucked underneath it. The mattress has a bellows-like effect as the patient moves about the bed. Studies show that contaminated mattresses, through these bellows-like motions, contaminate the air and other beds and linens in the same room. Studies have also shown that mattresses and blankets on beds ready for the admission of new patients were contaminated.

The procedure carried out in some hospitals of storing extra blankets together on a nursing unit and passing

(*Continued on Page* 124)

Condensed from a talk presented at Institute for Executive Housekeepers sponsored by Puget Sound chapter, National Executive Housekeepers Association and Association of Western Hospitals, Seattle, 1957.

Miss Heitman is hospital nursing consultant, Hospital and Nursing Home Section, Washington State Department of Health.

Wings for ward beds at University Hospital, Caracas, Venezuela. Another view of the bright colored exterior is shown on this month's cover.

Zigzag wall construction gives outside view and maximum privacy to every ward patient at the new University Hospital in Caracas

Bright Colors and Airy Balconies Enliven This Venezuelan Hospital

THE 1200 bed University Hospital in Caracas, Venezuela, was built at a cost of more than $30 million and opened in 1956.

The 11 story building is a continuous block of reinforced concrete, with a brilliantly colored façade. The interior of the hospital has been decorated in soft pastels, and the lobby entrance and two inner patios are brightened by colored murals created by Venezuelan artists.

Patient accommodations are planned for private rooms, semi-private rooms of two and four beds, and wards of five, seven, nine and 15 beds. An unusual zigzag type of wall in the eight wings for ward patients makes it possible to arrange beds in an accordion-like pattern, giving each patient his own view of the outside and individual control of the natural light coming from the side door to the outer balcony corridor. Telescopic curtain rods between sections of the wall provide privacy for the patients in these wards.

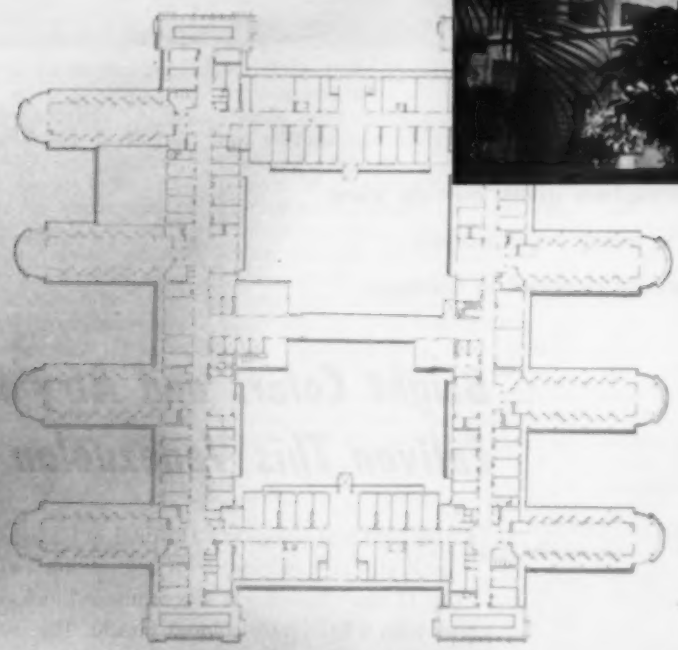
The hospital is administered by the Ministry of Public Health and is affiliated with Venezuelan Central University in Caracas. The active medical staff is drawn exclusively from the teaching staff of the clinical divisions in the university's medical faculty, although there also are courtesy, consulting and honorary staffs.

(For plan and photographs, see following two pages)

PATIENT ROOMS LINE CORRIDORS THAT SURROUND INNER PATIOS

UNIVERSITY HOSPITAL is designed around two inner patios or courtyards, with private and semiprivate rooms and necessary facilities surrounding them. A corridor connecting the front and rear sections of the hospital divides the patios. Ward beds are in wings or bays extending from the main corridors. As shown in the plan below, walls in the wards are staggered, so that beds can be arranged accordion fashion to give each patient maximum privacy as well as an exit to the surrounding balcony. Ambulatory patients use these balconies for relaxation in Venezuela's sunny climate. Private and semiprivate rooms surrounding the inner patios also have balconies.

Above: One of the two patios located within the hospital area. Plants, flowers, colored murals make view from the balconies pleasant. The project was designed and supervised by Dr. Jorge Soto-Rivera.

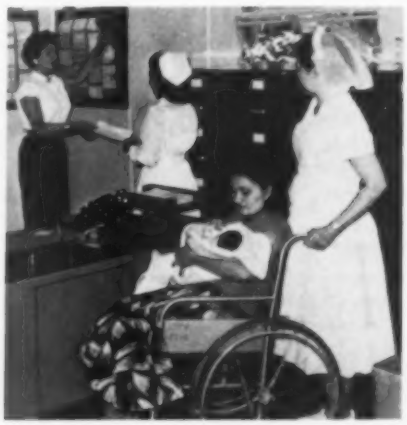


Left: Floor plan of University Hospital, showing eight wings of beds for ward patients. Private and semiprivate rooms surround the two patios.

Above, left: This view of the information desk in main lobby of University Hospital indicates massiveness of hospital's construction. Colored tiles and murals have been added to decorate this area. Above, right: A covered, lighted corridor leads the way to main lobby. Bright paint, plants add colorful note to hospital's appearance.

ACCORDION PATTERN OF BEDS AFFORDS PRIVACY TO WARD PATIENTS

Left, below: In this typical ward, the accordion-like arrangement of patient beds can be seen clearly. Curtains pull out to afford maximum privacy for each patient. Center, below: Admissions office, showing a part of bed control panel in the background. Right, below: This view of ward features the side doors giving access to the surrounding balconies.



Above: There are three cafeterias at the hospital to serve employes, students and medical staff. All kitchen and serving equipment is of stainless steel, modern design.

Below: The soda fountain at University Hospital is a gathering place for students and staff members, as well as a convenience for visitors to the hospital. Sandwiches, ice cream, and soft drinks are featured on menu.

ALL equipment at University Hospital is of stainless steel; floors are asphalt tile, and furniture and supplies were chosen from the best of the world markets, hospital officials say. Among the equipment is a movable television camera and six receivers. Provision has been made for color television cameras in every operating and delivery room, and a large screen for television viewing has been installed in the hospital's main auditorium, which seats 300 persons. The operating suite, on the fifth floor, includes nine operating rooms and an endoscopy room. Other operating facilities have been provided in the E.N.T., ophthalmology, traumatology and emergency departments. A recovery room, with individual outlets for oxygen and fluids, plus 15 especially designed beds, is located near the operating suite. Among the special services available at University Hospital are a blood bank, tissue bank, physical therapy, dental department, social service department, and scientific photography. A soda fountain and three cafeterias have been provided for employes, students and visitors.

Wanted: Nurses Who Carry Their Own Lamps

When they can stop arguing long enough to listen, doctor and nurse agree that what this country needs is a good, two-year-trained bedside nurse who has more technical training than the present practical nurse but who is not expected to administer anything at all—except routine medications and kindly, understanding treatment to her patients at the bedside.

EDITH A. AYNES, R.N.

IF FLORENCE NIGHTINGALE came back to life and went to work in a modern hospital, a student nurse said recently, she'd have somebody else carry her lamp!

Nurses who think this is an exaggerated view might consider a recent survey indicating that only 30 per cent of nursing personnel in the group of hospitals studied were graduate nurses—and more than one-third of the graduate nurses were in administrative or teaching, rather than nursing, assignments.

Caught in a four-way squeeze with the demands of doctors, nurses, nurse educators and patients pressing them from all sides, some hospital administrators blame nurses themselves for everything that is wrong on hospital floors. Others blame the government, or industry, or hospitals without schools, which use but don't train scarce nursing talent. Still other administrators simply look the other way where patient safety is concerned and hire women they call "nurses," rationalizing that a white uniform and some kind of nurses' cap is all that is required to attend patients.

With a little urging, both doctors and hospital administrators will admit that their most pressing patient care problem revolves around the nursing shortage, and they acknowledge that the greatest single item of cost in their hospitals is for nursing service. If they are completely honest, they will then tell you that even with the sums allocated to nursing service personnel, their patients are receiving the poorest *nursing* care in the recent history of hospitals.

Nurses will tell you, if you ask them —and listen to their answers—that hospital nursing is the least satisfying of all kinds of nursing available to them today. Why?

I would like to start with a conversation I had recently with the president of a state medical society in the Middle West.

This doctor and a number of his colleagues handle the medical needs of a small city, and they patronize the local hospital. His problem was not new, nor were his feelings about organized nursing. What *was* new was his willingness to discuss—and I mean listen as well as talk—the problem in terms of nurses and nursing needs as well as the needs of doctors and hospital administrators.

His first point was that the accreditation of nursing schools was causing many small hospitals to close their schools, thus eliminating the student labor so important to the operation of the small hospital already overburdened with expenses. I countered with the timeworn rebuttal of protecting standards for the student who is seeking an education.

"But all we want are *bedside* nurses," he reiterated. "We don't *want* these highly educated women. Oh, of course, you need a few but they aren't content to give the service we need."

I conceded that point, but asked about the student.

"Do you think you can get the high school girl of the caliber you want to enter a training school, work for three years in a nonaccredited school for practically nothing, and wind up at the end of that period with a diploma that blocks further education, keeps her from working in the better places—keeps her from civil service jobs, from jobs in industry, public health, and the service nurse corps?"

"I can fill my hospital right now with 25 girls who would be content

Edith A. Aynes is coordinator of information in the professional education division of the National Foundation for Infantile Paralysis. This work, however, she took up less than two years ago. She is a retired army major, with 20 years of military nursing duty behind her. In addition to serving on staff duty and as chief nurse in many overseas and stateside hospitals, Miss Aynes has been an instructor in the army's nursing service administration. She also has worked in the technical information office of the Office of the Surgeon General.

with that kind of training," he said earnestly. "They *want* this kind of an education, and this kind of work."

"I can't believe it," I said. "If they were content with that level of education, they would go into practical nurse schools. Why don't you start one of those?"

"Because practical nurses aren't trained enough for what we want," he said simply. "You can't expect a practical nurse to give an intravenous."

"In other words, what you still want is a nurse who can take a doctor's responsibility with nothing but on-the-job training and very little pay!"

"No, not that at all," he said patiently. "What we want are good, safe, bedside nurses who are content to stay at the bedside."

Four hours later we found we were in practical agreement:

What this country needs is a good, two-year-trained bedside nurse with a title that will permit her to stay at the bedside with the dignity of status and a living wage. A trained nurse with more technical training than a practical nurse's one-year course allows, but with a course condensed from the three-year curriculum that now graduates a product expected, upon graduation, to know not only bedside nursing with all its intricate specialties, but the art of teaching, training and supervising everything from a bedpost to contemporary graduates. Then, in addition, she is expected to reveal the management skills required by the hospital administrator who holds her responsible for the economical use of supplies, the fire regulations, the time schedules of personnel from the maid to the graduate staff, the supervision of the hospital at night, and the narcotic count.

SHE'S NOT AN ADMINISTRATOR

What is needed, it seems, is a two-year-trained bedside nurse who can safely and independently carry out the doctors' orders, but who is not to be saddled with anything administrative. She is not to be put in charge of a ward, a department, a group of patients, of time schedules, of handling personnel or equipment, of teaching the nonprofessional in or out of the classroom, of heading patient care teams for critically ill patients! She should not have such responsibilities unless she herself desires to change her status and is willing to take further education in a formal classroom to supplement her technical nursing skills with the management skills required for such leadership positions.

My medical friend was right. He could fill his hospital with women who prefer nursing patients to nursing leadership headaches. Seventy-two thousand (nearly 18 per cent) of the active registered nurses in the United States are practicing private duty because it is the only branch of nursing left where a qualified nurse can give total patient care at a professional level—with job satisfaction.

So our two-year-trained bedside nurse would be an operator—not a chief operator.

"But she will still be an R.N." my friend said.

"No!" I almost shouted. "Let's not confuse the picture any more. She must not be confused with either the professional nurse or the practical nurse, but she must be required to

Humanities Course for Nursing Students Helps Them Relate Art to the Nursing Arts

A COURSE intended to help student nurses see the relationship of humanities to science and to encourage use of their creative potential in these fields has resulted in a marked improvement in their relationships with each other and with hospital patients, according to Mary Jane Venger, director of nursing at Albert Einstein Medical Center, Philadelphia.

"The purpose of the program was to awaken the creative potentials of the student nurses and to open a path for the future development and application of these awakened skills in their professional lives as nurses and people," Miss Venger said.

Music, art, dance and the theater are included in the courses, started in 1952 at Albert Einstein Medical Center in cooperation with the extension department of the Settlement Music School of Philadelphia. The first course was a drama group that met weekly with an instructor from the school.

Encouraged by the results of this group, Dr. Pascal F. Lucchesi, executive director of the medical center, asked the settlement school to expand the program. Today it includes formal lecture courses during the day and workshops at night. Students may participate in one workshop in addition to the lecture courses.

Whenever possible, lessons demonstrate the relationship of the arts and the medical profession. Emphasis is placed on similarities of the learning process in both areas. This is necessary because students are accustomed to viewing each subject independently and have difficulty relating one to another.

In lectures on the history and appreciation of art, for example, the girls analyze elements of plastic arts, learning that these elements are found in all arts. The history of architecture also explores why man lives in houses and the sociological importance of modern housing and planned communities.

In the evening art workshop, students are introduced to drawing, painting, sculpture and clay ceramics. Discussions, slides and films are used. Posters related to nursing studies are prepared for display.

Lectures on dance and the theater are enlivened by musical illustrations, films and professional performances. Audience involvement in Greek and Roman theater, structure of Greek drama, use of modal music, and miracle and morality plays are included.

The modern dance workshop gives students a chance to improvise movement patterns, as well as learn the dances of others. Emphasis is placed on individual growth and development and on cooperative group feeling, rather than on professional dance training. Students learn to express themselves, to become less self-conscious, and to communicate with others.

In the music appreciation course, students are introduced to ear training by individual keyboard charts and limited use of the piano. Recordings are played and discussed, and guest lecturers give talks on the history of music and opera.

The choral workshop teaches vocal technics necessary in good singing, including sight reading, correct breathing, phrasing, tone quality, and interpretation. Each year the girls give programs for the Christmas-Chanukah holidays and the spring production.

The spring production, started two years ago, uses the talents of girls in each workshop. They have presented a folk opera, and staged an arts festival, which included an exhibit of their painting and ceramics.

Each public performance of any group has created good will and favorable public relations. The girls have appeared before many community organizations and have performed on radio and television.

pass a licensing test by the state, not only for the protection of the public, but as a means of establishing her educational level. She must be recognized as a fully qualified, trained, bedside nurse."

Promising a student a white cap, a white uniform, and an R.N. after her name is almost a requirement to obtain students for any professional nursing school, regardless of what kind of diploma she gets. In order to attract anybody these days, you've got to promise them something. Just as the military did in World War II:

"Join the WACS—save the wounded —replace registered nurses!"

When the emergency developed, the military had to make the best of what it could get. Women who served medical needs in the Wacs, the Waves, the Spars, the Marines, and the Red Cross nursing programs wanted to help, and they did help. But they would have been happier and more effective if they had had some training and organization before they were flung into hospitals and clinics—with sometimes downright unfriendly doctors and nurses to look to for guidance!

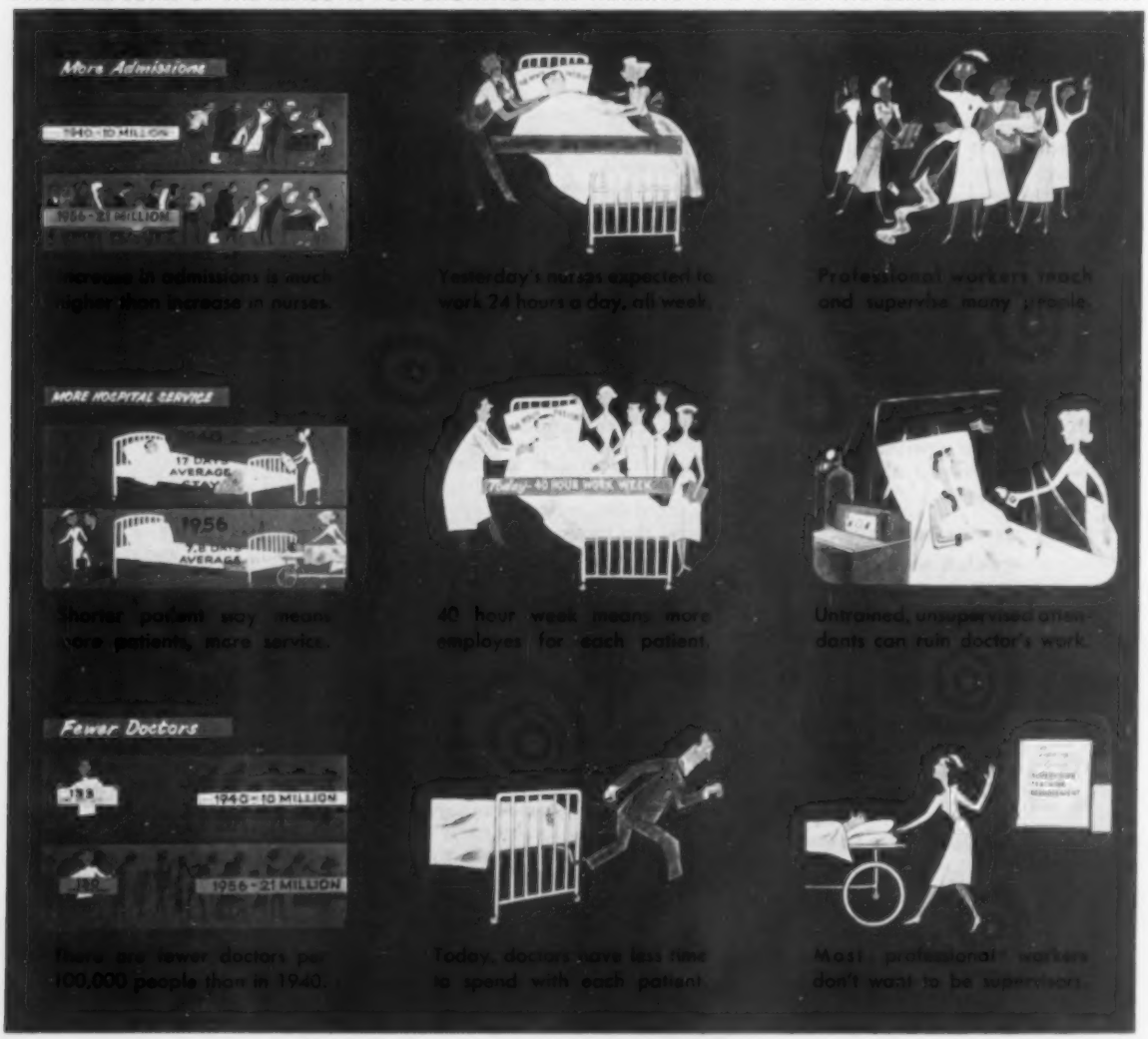
You can't use mirrors to take care of people in a military hospital, any more than you can use mirrors in a civilian hospital. It takes trained people!

In the armed services, the people giving nursing service to patients are divided into several categories: officer nurses, enlisted men and women, civilian employes under civil service —both graduate nurse and nonprofessional—Red Cross nurse's aides, volunteers and others.

In civilian hospitals, the people giving nursing service to patients are also divided into several categories: professional nurses, practical nurses, student nurses (both professional and practical), attendants, nurse's aides, ward maids, orderlies and volunteers.

Ward maids and orderlies correspond nicely to the untrained soldier or Wac; the nurse's aides and attendants are comparable to their counterparts in the military and to the hospital corpsman, and the medical tech-

HERE ARE SOME OF THE REASONS FOR SHORTAGES IN NURSING AND OTHER PROFESSIONAL DEPARTMENTS



Illustrations for this article are from the film strip, "Professional Education," produced by the National Foundation for Infantile Paralysis, 301 East 42d Street, New York City.

nician compares with the on-the-job trained practical nurse.

Essentially the military has the same nursing problem as the civilian hospital—only the military is more complicated. Where the civilian hospital has only a board of trustees to convince, the military hospital has the whole government making decisions that affect it, and military doctors—being civilian trained—are just as unfamiliar with nursing problems as are their civilian colleagues.

"We don't want a bunch of blankety-blank generals!" a colonel-doctor roared at me during a regular army nurse commissioning session a few years ago. "We want some bedside nurses!"

COMMISSIONED BY THE ARMY

Yet the army—presumably with the approval of doctors—established the Army Nurse Corps more than 50 years ago on the basis of one nurse to 10 beds: teachers of nursing to supervise the care of the sick. Soldiers were supposed to benefit from their training. Nobody ever explained to those early graduates of Florence Nightingale schools that they were teachers. With the backing of the medics and civilian nursing, the army nevertheless commissioned the products of state-approved civilian schools of nursing, regardless of the educational standards of the school involved. With the full support of the American Nurses' Association and at least the tacit approval of the American Medical Association and the American Hospital Association, graduate, registered nurses from some of the smallest schools in the United States as well as the largest are commissioned as potential leaders on the same basis, with the same pay, privileges and responsibilities, as leadership candidates from West Point and the R.O.T.C. programs.

Whether anybody likes it or not, or approves of it or not, the hospitals in our economy and other agencies needing nurses have only one source of supply for graduate, registered nurses: the eleven hundred some odd civilian schools of nursing. All these schools of nursing, whether they are attached to a 10 bed hospital without an instructor, a 50 bed hospital with one half-time or full-time instructor, or to the largest universities in the country, issuing degrees instead of diplomas at graduation, produce only one level of worker—the nurse who takes the state board in her own state and becomes a good, bad or indifferent R.N.—a professional nurse.

Right now it matters little where the nurse works or from what school she graduated, she finds herself in a position where she must work with subordinates. In theory, since she is registered by the state, she is a better bet than the attendant hired away from the local ice cream factory, and presumably she is capable of safeguarding the medications and treatments ordered for patients under her surveillance. But, just as in the case of the one-nurse-to-10-beds-ratio in the army 50 years ago, she isn't supposed to let on that she knows this is her function. By some funny scheme, the nurse is supposed automatically to take care of all the patients that need her attention—and leave alone those who do not. She is automatically supposed to satisfy all the demands of the medical staff that need her level of assistance and stay out of the way for the rest. She is supposed to keep all the administrative matters under control that her crystal ball tells her the hospital administrator wants her to handle—and leave the others strictly alone.

LACK OF COMMUNICATION

All this she is to do without much guidance. The lack of communication and feedback between the top level of hospital administration and the nurse who is working at a foreman's job is appalling. Why should a hospital administrator listen to what a general duty nurse has to say? In the eyes of the doctor or the hospital administrator, a nurse is a nurse. Nurse's aides, practical nurses trained or untrained, attendants—anybody with a uniform—can be a nurse! If nursing leaders want to provide better qualified head nurses and supervisors and think they should educate to that level so professional nurses will be professional in fact, as well as in fancy, the doctors and hospital administrators shout: "We don't want a bunch of blankety-blank generals. We want some bedside nurses!"

For a few years following the Second World War, I was optimistic that something constructive would come out of the nightmare we had gone through when the military need had jumped from 639 to 57,000 graduate registered nurses. Even after the war, civilian hospitals, scraped to the bone, were relying on student nurses and overworked graduates to take care of civilian patients. The situation approached chaos. Surely, I thought, somebody would do something to make sense out of the whole mess before we got into another international misunderstanding!

But everybody has been too busy! Men who learned tricks about hospital administration in the medical administrative corps scurried out to get administrative jobs in civilian hospitals. Doctors who learned about new medications and new surgical technics scurried out to establish themselves in the best possible places in civilian communities.

Nurses, appalled at the confusion and turmoil and the lack of understanding that surrounded their efforts in both military and civilian hospitals, returned to classrooms wherever they could to try to learn the technics of teaching nonprofessionals and the intricacies of administration, so they might make some sense out of their own profession. But nurses not only went to school, they went into public health, school programs, industry—anything that would keep them out of hospital wards.

Why?

1. Because hospital administrators, with their newly found stature, would not concede that anything administrative belonged in the jurisdiction of the nurse. She should just take care of patients.

2. Because doctors would not concede that anything professional belonged in the jurisdiction of the nurse. She should just take care of patients.

3. Because nurses, faced with both administrative and professional problems in the care of patients, had little backing and no authority to recommend organizational changes or even to complain effectively about things as they were.

FLOCKS OF UNTRAINED PEOPLE

Today there are flocks of untrained people under foot on hospital wards who are not capable of giving safe nursing care to patients, people who are encouraged by both doctors and hospital administrators (and a few nurses) to do procedures that nurses with consciences feel are too dangerous for untrained or semitrained people to perform unsupervised. The bulk of the nurses are not trained as teachers, they are not trained as supervisors, and they do not want to accept the nursing care responsibility for patients when there are too few trained people to help them. They feel that any person in contact with sick patients should be conversant with new technics, new drugs, new equipment, and know the effects on the human body of such drugs and treatments. When the work load becomes impossible for them to give or even supervise the nursing care themselves, they seek work elsewhere—where a conscience off duty can rest.

After four hours of discussion, the president of the medical society and I were in complete agreement: What this country needs is a good, two-year-trained bedside nurse! A trained nurse who, upon completion of her training, would not be a head nurse or a supervisor, would not be a public health nurse, or an industrial nurse,

or a nurse anesthetist, or an operating room supervisor, or an educator —and she would not be eligible for a commission in the armed forces!

This trained bedside nurse would have an in-between status of her own —something like a warrant officer's rating in the military. She would have periodic pay increases at intervals, up to what it takes to keep her on the job if she's worth it. She should have the opportunity to become a senior bedside nurse—a promotion comparable to the chief warrant or petty officer in the military. But if she wanted to become a professional, she would have to return to a civilian university and obtain the necessary education.

The area of nursing below the professional level should be a career in itself. Teaching, supervising, nursing administration require more than a three-year diploma, not only for the sake of patients, but for the sake of the poor devils who have to work on nursing services and in nursing departments under the guidance of the so-called professional nurses.

The two-year level is also an opportunity for the practical nurses to prove they can go on; whether they should be licensed by examination or by sweating out the course for two years would have to be settled by state boards of nurse examiners. The state board requirements for licensing should make these people realize that they not only have legal responsibilities, but also they have legal limitations on their activities. Licensure should help the individual remember that the practice of medicine is a full-fledged doctor's responsibility requiring five to eight years or more of education—whether the doctor is around all the time or not!

WHAT SCHOOL WOULD DO

The two-year school of nursing would do several other things: It would answer the smaller hospital's need for cheap labor and at the same time meet the needs of many girls who cannot afford the more expensive education that goes with professional nursing. Many girls cannot meet the educational requirements, let alone the financial. This level of training would make possible the expansion of the nursing service of the nation without danger to patients.

The nursing aspects of medical care and treatment, the ethics that surround doctors, patients and hospitals, would be stressed in this two-year course, along with human relations. Cooperation with professional and practical nurses, not competition, would be emphasized As a result, workers would not be subjected to the tactics of untrained nurse managers who neither know how, nor want, to train and supervise at the bedside.

Nursing is having a feeling for people—a human feeling that makes it possible for you to serve them and their often disagreeable sickroom needs around the clock, with compassion, sympathy and understanding. Teaching nursing, supervising nursing, inculcating the ethics of nursing into people and inspiring them to give that nursing care in a compassionate, sympathetic and understanding manner is an entirely different job. But you have to understand the first before you can accomplish the second.

Hospital administrators make their greatest mistake, waste the most money, in believing that quantities of people can substitute for quality in nursing.

Consider one of the prototype studies published in The Modern Hospital last year, for example. The 600 bed hospital was reported as having an average daily census of 482 patients with 51 newborn.

ONLY 30 PER CENT WERE R.N.'s

To give nursing care to patients and to staff operating rooms, delivery rooms, outpatient clinics, central supply departments, teaching schedules, head nursing jobs and supervision around the clock, the 600 bed hospital employed 754 people, only 30 per cent of whom were graduate, registered nurses. Less than half these nurses were general duty nurses, and even including the part-time nurses employed, they accounted for only 20 per cent of the number of people employed as nursing personnel.

Of the 528 less-than-professional personnel, 260 were student nurses, 39 were practical nurses, and 229 were other employes, identified as nurse's aides, orderlies, maids and attendants. Under these circumstances, the graduate staff, whether it is acknowledged or not, must be, of necessity, in leadership positions, even as general duty nurses. Yet surveys reveal that only about 30 per cent have the required interest, personality, education and other qualifications for such responsibilities.

Thirty per cent of a staff that includes all levels of workers should *all* be leaders—not just 30 per cent of 30 per cent!

Suppose the nurses who lack leadership qualities and ambitions could be designated as trained bedside nurses, and the best practical nurses, nurse's aides, and attendants could be given enough training to bring them to a two-year level of education and licensed as bedside nurses. This group, along with new recruits to two-year schools, will soon make up a staff of bedside nurses who know and understand the nursing aspects of medical technics, who want to practice them and can be legally responsible for doing them right. Let this group, under the administrative guidance of the professional head nurses and supervisors, give nursing care to patients. But fire the first head nurse or supervisor who fails in her rôle as supervisor or teacher when the staff asks for help!

MUST BACK UP THE DIRECTOR

A third of the remaining force should be trained practical nurses so that the skills and abilities of the bedside nurses will not be wasted with less than the acutely ill. If your professional staff are true leaders, you will find you can probably cut the size of the paid staff to about one-half what it is today—but you will be required to back your director of nurses on matters that affect nursing service, and include your total professional staff in your communications system. Mental telepathy is not taught in enough schools to make it effective, in either direction, in the hospital.

Nearly one-half of your nursing staff is now trained to a safe level; one-third is in an understudy position, and the other one-sixth has an opportunity to progress if they want to make the effort. Any person at any level can stay at that level, if she prefers. With this kind of an organizational structure in civilian institutions, nursing service could be expanded to meet a national emergency, but instead of drafting only graduate, registered nurses and untrained enlisted men and women, a portion of each trained group could be ready for the expansion, and a like portion could remain at home. The main idea is to have an organized nursing service and get your money's worth from the people you hire at the level you hire them, both as a civilian hospital administrator and a taxpayer. If you are going to have to pay commissioned officer salaries to nursing personnel, in or out of the military, for goodness sake require the qualifications and performance that go with them. But don't leave them stranded at the top of the ladder with nothing between them and the bottom rung.

The time should be long past when we, as patients or taxpayers, can afford to pay lush salaries to haloed Florence Nightingales because they once graduated from schools of nursing and practiced nobly at the bedside of patients. Top level performance in nursing leadership should be the criterion for high sounding titles and big salaries, in any area of our national economy—government or civilian. Especially when somebody else is carrying the lamp.

How to Collect Good Will With the Bills

A credit man offers a realistic and fair approach to hospital collection problems that will earn the respect of the community and will also provide the income needed to give good service and allow for expansion

JOHN W. JOHNSON

THE hospital industry, not too surprisingly, is the largest single granter of credit in the nation. The watches, automobiles, refrigerators and television sets bought on time; the total of department store charge accounts; the total of any single commercial industry involving credit—these do not equal the amount of credit granted by hospitals.

Although three or four industries have greater income, spend more money, and hire more people than do hospitals, not one is as dependent on credit.

When a patient presents himself for a stay at a hospital, payment for which is expected five or 10 days later, he is granted higher credit than he is likely to get anywhere else in his community.

His high credit at local stores may be $50 or $75. His high credit at local loan companies may be $300, with cosigners. However, he could easily run up a $600 or $700 bill at a hospital, and, if he hasn't paid in advance, he has run that bill on credit.

While half the TV sets, half the automobiles, and 70 per cent of department store items are bought for cash, 90 per cent of hospital income is put on the books and paid later.

Hospitals not only are granting credit but, because of their nature, they probably are granting credit to a large number of people whose credit in the community is not good, perhaps to people who couldn't get anything on credit anywhere except at the hospital.

Even when an insurance company is involved, credit is granted. By presuming that the policy is in force, that the patient will cooperate in completing the insurance company questionnaires and other requirements, and that the patient's condition is covered by the policy, hospitals are granting credit.

Since hospitals grant such an enormous amount of credit, they certainly should have good credit applications. Each admitting record is a credit application, and it should contain all vital statistics that good credit applications contain.

In reality, collection problems begin with the admitting desk. The information contained in the admitting record is the only "method of location" in the event the patient moves before paying his bill. The information also will reveal ways in which the patient can pay the bill he thinks is beyond his present financial resources. In fact, just asking the questions encourages payment. It tells people that the hospital means to collect, that it is run in an efficient and businesslike manner.

A good admission record should include the patient's full name and address and that of the responsible party, as well as his residence, employer, bank references, business references, close relatives, and all addresses. In addition, the mother's or wife's maiden name and all telephone numbers may at some later date help the collection department or a collection agency find the patient if he moves without leaving a forwarding address.

One good way to improve collections is to make the admitting department understand that the principal aim is to get information that will be helpful for credit purposes. By this one adjustment in hospital thinking, collection problems can be cut in half.

A serious problem faced by hospitals is payment for services to the aged. As a general rule, these patients are the most poorly equipped to pay and, because of the general nature of their illnesses, they are faced with the longest stays and highest hospital costs.

In many cases, adult children pay hospital bills for their aged parents. However, the number of children who promise to pay and then fail to keep their promises is alarming. Some make direct promises to the hospital about payment; some talk to the doctor; others promise parents that they will pay or tell their parents not to worry; some parents assume their children will pay because they pay everything else. Unfortunately, none of these promises—even the direct oral guarantee to the hospital—is ac-

Hospitals are making progress with reducing their credit losses, but they still have a long way to go, says the author, who is executive secretary of the American Collectors Association with headquarters in Minneapolis. The association has been working with state, regional and national groups of administrators for some years to help them establish businesslike credit and collection procedures, he reports. A graduate of the University of Minnesota, Mr. Johnson is a member of the advisory board of Asbury Methodist Hospital in Minneapolis.

ceptable in court, if the hospital must resort to this to collect.

Even if adult children bring an aged parent to the desk, even if they say they will be responsible, even if they make some payment on account, they absolutely cannot be held legally. Even if they do all of the things just mentioned they are not legally bound to the obligation.

The hospital must have a written guarantee. And, whatever is true about the responsibility of adult children for the aged also applies to parents responsible for children who reach their majority, for one adult brother or sister guaranteeing for another, or for any third-party guarantee.

A good third-party agreement used by many hospitals today reads as follows:

"In consideration of and to induce the.....(name of hospital) hospital's admitting and/or retaining..... .....(name of patient) as a private patient, the undersigned, the..... (name and relationship of undersigned to patient) of the patient hereby assume(s) full responsibility for and agrees to pay all costs, charges and expenses of the hospital of every kind and description for services, facilities, food, medication and any other thing supplied or furnished the patient. This is an original undertaking on the part of the undersigned, and the obligations of the undersigned hereunder are the direct and primary obligations of the undersigned to the hospital. No extension, indulgences, or forbearances which may be granted to the patient and no delays or lack of diligence of

THIS PREVENTIVE CREDIT PROGRAM HELPS PATIENTS PAY THEIR BILLS

THE patients' accounts department of Massachusetts Eye and Ear Infirmary, Boston, concentrates on preventive credit rather than collections.

Next to illness, money strikes the patient where it hurts most. No patient progresses rapidly if he is beseiged with worry. Once we have assured him of our best care, we then tackle the bill problem so that our patient goes to his room with as free and relaxed a mind and body as we are capable of giving him.

This policy also is carried on in our collection work. We know that each person can easily influence 10 more, and those 10, one hundred more. On it goes, until finally a hospital is established in the public's mind either as a humane and understanding part of the community or as an institution concerned only with cold facts and figures.

Our office is in the admitting area where we work closely with each admitting officer. When an admitting interview discloses a financial problem, the patient is referred to our department, where we quickly establish the fact that we are here to help the patient. We rarely find any reluctance to answer our questions.

The admitting nurse can interview more patients when she can refer time consuming financial problems to this department. Only the department responsible for collections knows the true credit picture and what type of person to assist, watch for a credit problem, or ask for a deposit.

We avoid asking for deposits whenever possible, except from out-of-state patients (with no insurance), cosmetic cases, such as elective plastic surgery, and obvious credit risks. We feel the good will gained by this policy balances the few bad debts we have as a result of no deposit. Since we began our present policy of good public relations in collections, the percentage of bad debts has decreased from 2.6 per cent in 1954 to 1.9 per cent in 1957.

On interviewing a patient who has no visible means of paying his bill, we first establish whether he is eligible for welfare assistance.

A large percentage of our patients are 65 and over, barely getting by on a pension and social security. In these cases, we suggest they seek old-age assistance from the board of public welfare. Frequently such a suggestion meets with disapproval, but when we explain this is not permanent assistance but only aid for hospitalization, they are willing to make application. Other public welfare categories are disability aid, aid to dependent children, and aid to the blind.

If the patient is not eligible for welfare assistance and is not a resident of Boston, we then think of general relief. In Boston, general relief can be given only to those who use Boston City Hospital.

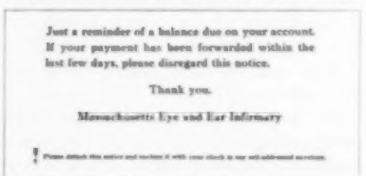
With few exceptions, however, many towns and cities have a general relief fund that allows them to assist a certain percentage of their medically indigent people. This we also use for out-of-state patients, providing their state does not have proper facilities for their care.

A certain percentage of our bills for veterans or their dependents are paid by veterans services.

By discussing finances with a patient prior to admission, many collection problems are avoided. Often families are more willing to help out before an admittance than they are when the patient is home and the care already has been given. Some people have an erroneous idea that, unless they pay a hospital, care will not be as good. This, too, is a reason why people assure us of payment in full when they really do not have the funds to pay.

We seldom "free service" patients on admission. Naturally, there are the few whom we know cannot pay anything because of varying circumstances. We do not offer free service to these people on admission, but we prefer to tell them on discharge. With most cases, we admit them at the regular rate and request they make monthly payments, if they cannot pay in full. Some of these patients, we know, will need assistance as time goes on. Experience has shown that if a patient knows a hospital wants its bill paid in the same manner as the car and television dealers, his efforts to pay are most ardent and realistic.

FIRST REMINDER OF BALANCE DUE


Just a reminder of a balance due on your account. If your payment has been forwarded within the last few days, please disregard this notice.

Thank you.

Massachusetts Eye and Ear Infirmary

The polite reminder is printed on the envelope in which the bill is sent, so it can't possibly be overlooked.

If we automatically offered free service on admission, other patients from the area would come in and say they could not afford to pay either. Also, if a patient is given free service on admission, he then may talk about it in his ward. I wonder if credit managers stop to realize how much convalescing patients talk to each other!

We are reasonably certain that if a ward patient has been steadily paying a large bill at the slow rate of $1 or $5 a month, he is a sincere per-

At the time this article was prepared Mrs. Slade was director of patients' accounts at Massachusetts Eye and Ear Infirmary, Boston. She has since left the hospital to take another position.

the hospital in enforcing any rights against the patient shall in any manner release the undersigned or affect the undersigned liability hereunder. If the undersigned is more than one person, every obligation hereunder shall be joint and several. The obligations of the undersigned hereunder shall be cumulative with and in addition to all other remedies of the hospital against the patient."

Space for names and addresses of those assuming responsibility, for the witnesses, and for the date are provided at the end of the guarantee.

Occasionally hospitals are called on to finance the cost of a patient's accident, in this way: Until the suit is settled and judgment is given in court for the patient to recover hospital costs, he feels that he is not responsible for the hospital bills caused by the accident.

A simple argument that can illustrate the hospital's position is to ask whether the patient's clothing was ripped or damaged in the accident. Of course, it usually was. It then can be pointed out that the patient would not expect to go to a department store, replace the item of clothing, and ask the merchant to wait for his money until recovery was made from the insurance company. Then, it can be explained that the hospital must get the same consideration.

Some hospitals deal with farmers who want to postpone payment until the next crop comes in. Their income is cyclical.

There also are city people whose income is cyclical, who are in seasonal businesses or who sell capital

BECAUSE IT PREVENTS THE BILLS FROM PILING UP

MARILYN M. SLADE

son who recognizes his responsibilities but could use some help. He is the one we try to assist (provided we know his true financial history), not the one who says, the minute he enters the hospital, "I can pay nothing on my bill." Our experience has shown that this latter person usually can pay more than the one who at least tries to pay.

We closely follow the patients' accounts while they are in the hospital to prevent any large balances from accruing unnoticed. If a patient is well enough, we visit him. Many times a patient says, "I'm so glad you came, I've been worried about my bill."

If the patient is not able to discuss bills, we call the next of kin. Because we have many cancer cases, patients often stay much longer than they had anticipated. Here again, we review the account and offer what suggestions we can.

The other responsibility of our department is insurance. One person has charge of obtaining the insurance forms. The assignment of benefits must be signed if the patient is not

FOLLOW-UP—NOTICE OF BALANCE

May we have your payment now?
However, if circumstances have arisen which make it difficult for you to pay your bill as agreed, please call or come in and discuss this with us. We wish to cooperate with you in every way.

Massachusetts Eye and Ear Infirmary

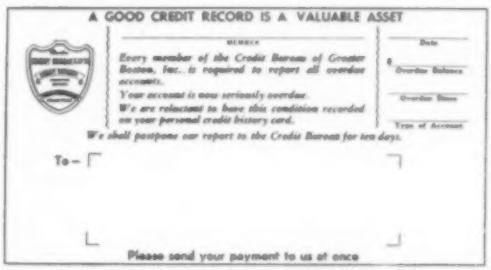
This notice, sent when the balance remains unpaid, offers the patient a chance to explain his problems.

paying his bill on discharge. Unfortunately, there are those who collect the insurance and do not pay the bill. The assignment of benefits avoids this.

One of our problems is out-of-state insurance. If possible, we try to obtain proper authorization from the insurance company before the patient goes home. We do not require a full deposit from out-of-state patients when they have insurance. I sometimes wish we did when we receive rejections and benefits lower than expected.

NOTICE WARNING THAT BILL WILL BE SENT TO CREDIT BUREAU

This credit bureau notice is not sent until the account is from 60 to 90 days old. It has proved to be extremely effective.



When the insurance company has not paid us within a month, we notify the patient, asking him to check with his agent or the bill will become his own responsibility.

So far, we have talked mostly about the patient on admission, but a large part of our public relations is concerned with the patient after discharge.

Once the cashier has made the original billing, our department takes over. This is where the hospital must remember the importance of community relations. If the patient is met with an unpleasant attitude toward his bill, he will remember this more than his good treatment. A collector once told me that a patient with an unpaid bill is a far greater public relations hazard than one who has paid his debt.

Theoretically, we should have no private patient collection problems, but we do. The reasons vary. One is rejected insurance, when the patient has not checked with his insurance company prior to coming in and when it is not possible for us to reach the company before the patient goes home. Other reasons are stays longer than expected or people who request private accommodations but are not able to pay.

Any patient who has to pay his bill on a monthly basis should not be a private patient. If a patient is sent in by his doctor, we assume he is capable of paying his bill. Unfortunately, there are times when neither the doctor's office nor our admitting office can judge a patient's paying ability correctly. This is when our collection problems begin.

Several of our effective collection notices are illustrated here. The printed messages are excellent timesavers for the first notices. After these we try to call the patient in the event there is a misunderstanding about the bill. The credit bureau notice is most effective. When it does not bring in payment, we know we have a difficult collection problem. This notice is not sent until the account is 60 to 90 days old.

At all times, we handle our accounts individually. Because we have fewer

(*Continued on Page* 128)

goods or commodities where the purchasing unit is high and several months elapse between one commission and another. They are no different from the farmer who gets a monthly milk check and seven or eight other checks during the year as his crops are harvested. In fact, many hospitals today feel it is discriminatory to expect one group to pay on time while another group gets extensions from one season to the next.

Hospitals can improve collections from farmers and, at the same time, help them to manage their own finances more efficiently by insisting that they must meet their obligation for hospital care.

It is not easy. It is difficult. But you can succeed, and the word will go down the rural routes that the hospital, like other institutions, expects to receive payment for services.

To this point, we have been talking primarily about credit extension. However, to be successful, this must be followed by a definite collection policy. A prompt and careful program of regular billing is fundamental.

Many hospitals send a simple statement at the end of 30 days. They include some short reminder letter or notice with the second statement at the end of 60 days. If statements are ignored for two months, further statements seldom will do any good.

It is here that hospitals should recognize that the value of past due accounts rapidly deteriorates and that some action must be taken to bring payment.

A recent survey by the American Collectors Association revealed that uncollected accounts depreciated to a value of 80 cents on the dollar when they were two months old and to 67 cents after six months. The drop in value after six months was quite rapid. These figures are for the average claim, which usually is better secured than hospital claims and involves goods and services of an elective nature that do not combine themselves with the loss of income that a hospital stay often does.

Surely no account should remain on the hospital books for more than 90 days without payment's being arranged by the patient or an insurance company. Perhaps this can be extended to 120 days in rural areas, but certainly it should be 90 days in the cities. If the patient does not arrange for payment within 90 days after discharge, there is no reason to feel he ever will, unless a new element, the professional collector, is introduced.

If, after 60 days, two statements and a reminder notice have been sent to the patient with no response, it is time to use some other means. A good technic is to call the patient by telephone and attempt to collect in full. It is up to the telephone collector to sell the patient on paying the bill. This can be done only by pointing out how the patient will benefit from having his account cleared. We call these sale points motivating factors.

If it is impossible to collect over the phone, arrangements should be made for the patient to come into the hospital for an interview, at a stated time, *i.e.*: "We are making an appointment for you at 3 tomorrow afternoon, or would sometime earlier in the day be more convenient?"

Incidentally, this same approach can be used on the second letter in the collection series by writing to the patient and telling him an appointment is scheduled at "4 o'clock Friday afternoon." Patients usually will come and, if they can't make it, frequently will call to arrange another time.

It is the personal interviewer's job first of all to determine the patient's intentions. Is he a staller; does he have a grievance; does he dispute the amount of the bill and want some adjustment; does he think he has insufficient funds; is he, in fact, unable to pay, or is he the type of person who will not pay but can be forced, or is he in the final category of those who neither will pay nor can be forced to pay?

The last category is seldom encountered in a personal interview situation. If the patient is not going to pay, he will not bother to come in to see you.

EXPLAIN TO THE PATIENT

Once you have determined the problem, it often is fairly easy to find a solution. For example, if the patient thinks he should have an adjustment, that he was billed for an extra day, or that he didn't order a particular medicine, it is up to the interviewer to check the hospital records for the reasons and explain them to the patient. Occasionally, the hospital may find a statement is incorrect; if so, an immediate adjustment often will bring payment of the bill.

Sometimes patients who think they cannot pay have assets they have not considered. For example, many people are saving "war bonds" for a "rainy day." The interviewer can point out that the rainy day has arrived and that this is why the bonds have been saved. Patients often have a credit union at their offices or shops where they can borrow money at a low interest rate. They may have loan connections through insurance companies, relatives, employers, a bank or loan company where they can work out a loan so that the hospital can be paid in full.

Other assets the interviewer should discuss are checking accounts, savings accounts, defense bonds, automobiles, farm equipment, livestock and crops, insurance, home and other property.

If all sources for payment in full are exhausted, then, and only then, the interviewer should set up a payment plan with the patient. With the information the interview has developed, he can estimate the maximum a patient is able to pay. It is unwise to allow a patient to obligate himself to pay more than he is physically able to pay. This will result in a broken payment promise, necessity for another interview, a new payment plan, and a general discouragement of the patient.

If a payment plan is broken by the patient for any reason, tear it up, call the patient in, and start over. Once the payment plan has been broken the first time, the second violation will come much more easily.

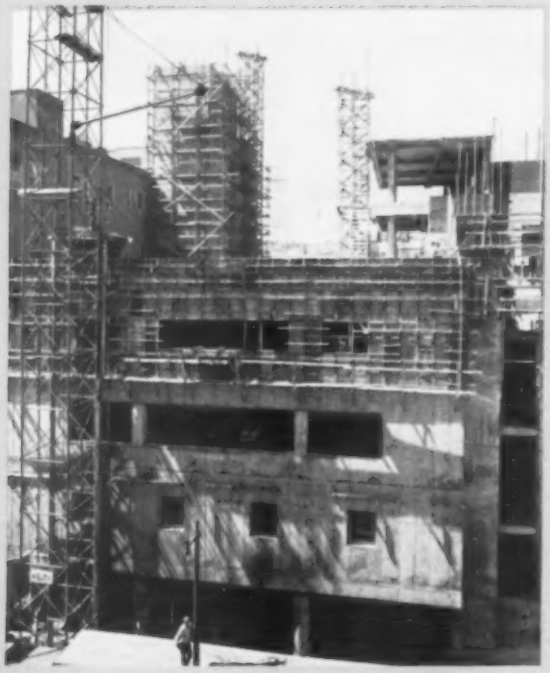
Finally, we often are asked: "When should a hospital account be referred to a professional collector?" The best answer we can give is that professional collection help should be called in when the hospital has lost effective contact with the patient. If he refuses to answer mail, if letters come back marked "Moved, no forwarding address," if he has stopped meeting installments on a payment plan, if he has been giving excuses month after month, or if he flatly refuses to work out any payment plan, it is time to assign the account to a collector.

We strongly urge that the hospital assign the account to a collector in its own community. To do business with a local, established businessman will ensure more efficient and more effective collections and foster a close working relationship with this new addition to the hospital staff.

In review, if hospitals follow these few suggestions, they can greatly reduce their collection problems:

1. Get good admission records. This is the patient's application for credit.
2. Establish a liability for bills that will not be paid by the patient and have the responsible party sign the agreement.
3. Have a regular billing and collection procedure on every account.
4. If the statements or collection letters do not bring the desired results, attempt to classify the debtor to learn the reason for nonpayment and then work out payment in full or the best payment plan.
5. As soon as effective contact with the debtor is lost, refer the account to a collector.

Addition under construction, St. Francis Memorial Hospital, San Francisco

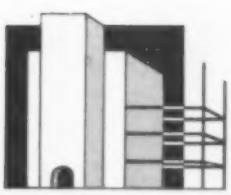


As we look ahead to continued population growth in all kinds of communities, hospitals must plan now for orderly expansion of existing buildings. In the following pages, planning and building authorities talk about

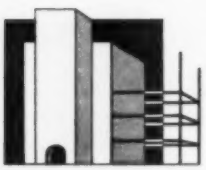
ADDITIONS

in meaningful discussions that should help hospitals decide when to build, what to add, and how to get the job done with a minimum of grief for everybody

Survey of Addition Projects	*Page 68*
Round Table on Building Additions	*71*
Planning to Meet Community Trends	*72*
How to Evaluate Old Buildings	*76*
Avoiding Problems on the Job	*79*
Programming Departmental Needs	*87*
Checklist for Planning Departments	*90*



Building survey reveals addition problems



Results Tell Why Additions Were Built, What They Contain, and How Day-to-Day Problems of Building Were Resolved

SHEPARD D. ROBINSON

OPERATING the hospital during the construction period and relations with the contractor and the architect are the principal problems faced by hospital administrators involved with building an addition to their existing plant.

This is the major conclusion to be drawn from a survey on the subject of additions recently compiled by The MODERN HOSPITAL.

Two other principal conclusions indicated by the results are:

Patient areas and food service installations are the commonest facilities that are being added or enlarged at hospitals.

Approximately one-half of the additions being built involve general expansion of the entire hospital plant rather than expansion of particular facilities in the hospital.

The questionnaire was sent to the administrators of hospitals which had undertaken addition building projects within the last two years.

A covering letter asked the administrator: What did you learn while putting up your addition that you wish you had known before you started the project? What rules, applicable to all additions, could you promulgate?

Amplification was sought in eight areas of the addition building problem. They were:

1. What caused you to expand?
2. Did your expansion fit into a long-range plan?
3. What facilities did you add or enlarge?
4. What determined the specific facilities added?
5. What new equipment did you incorporate into your addition?
6. How did you raise the money for your addition?
7. What about operating the hospital during the construction period?
8. Is there any difficulty you encountered, not covered here, that would be helpful to another administrator?

Of the hospitals surveyed, 66 per cent had nonprofit or church ownership, while 33 per cent were governmental. Thirty per cent characterized their location as rural, 57 per cent said it was urban, and 12 per cent defined it as suburban.

GROWTH FORCES EXPANSION

Preliminary interviews indicated that pressures on the hospital to expand had two sources—those from the outside over which the hospital had no control and pressures from within the hospital.

A growth in population in the hospital's trading area, a rise in prepayment insurance memberships, and increased assumption of responsibility by governmental units, *i.e.* in state mental health and veterans administration hospitals, were cited by 51 per cent of the administrators who responded to the questionnaire as outside influences that brought about expansion. One administrator said that the major reason for his board's authorizing an expansion was a desire to take advantage of funds that were offered for that purpose.

A lack of space, the need for services, such as recovery rooms, that have been developed since the hospital was built, and the fact that old buildings were no longer usable or efficient were listed by 90 per cent of those responding to the survey as inside pressures for expansion.

One of the administrators interviewed reported that the doctors in his community had formed an x-ray clinic and a cast and physical therapy clinic when pressure on the hospital had become so great that it was unable to provide the kind of service in these departments demanded by the doctors. This threat to income producing units was an impelling factor in the addition.

Faced with the pressure of an increasing population and lack of space, the hospital must do some serious thinking. Does the hospital want to expand at all? Is there anyone else to do the job? If not, presumably the hospital must.

Concerning whether the hospital wants to expand at all, the survey revealed that a considerable number of administrators felt that their recent expansions had brought their hospitals up to the maximum number of beds they expected their hospitals to grow to, apparently that it had become as large as the administrator wanted to handle or the board wanted to finance.

This whole subject, of each administrator feeling that there is a point beyond which he would not want the hospital to grow, is an interesting one. Interviews reveal that the administrator of a 50 bed hospital feels that "the hospital becomes a factory" when it grows beyond 100 beds, the administrator of the 175 bed hospital feels that 250 beds is the most he would want to handle, while the 600 bed man says that 900 is his maximum. One architect consulted was most emphatic in stating that the needs of the

community, not the feeling of the administrator or the board, must dictate the growth of the hospital. He held that planning centered on one individual was bad planning.

Seventy-eight per cent of the hospitals responding to the questionnaire indicated that they had a long-range plan. It was evolved by the board and the administrator in most cases. One respondent held "Topsy" accountable, 39 per cent said their architects had participated, only 6 per cent employed a consultant, and one administrator said that the architect alone had evolved their long-range plans.

Asked what planning services were utilized in the addition under question, 97 per cent of the administrators named the architect. Fourteen per cent of the projects had the advice of a consultant, and 12 per cent of the administrators said that they used the planning services offered by manufacturers in planning their additions.

It was interesting to note that while 78 per cent of the hospitals questioned said they had long-range plans, only 48 per cent said that the addition currently under way was anticipated in the long-range plan.

Fifty-one per cent of the administrators responding indicated through a checklist that their additions were general expansions in all departments rather than the addition of selected, specific facilities.

Patient areas, added in 82 per cent of the hospitals queried, and food service facilities, involved in 70 per cent of the additions, were the two commonest categories added or enlarged, according to those who answered the questionnaire.

Other facilities added or enlarged, and the percentage of additions that included these departments, follow:

Operating rooms, recovery rooms, and central supply, 57; diagnostic services, 51; therapy and rehabilitation, office space, and outpatient facilities, 48; storerooms and pharmacy, 45; emergency and power plant, 40; obstetrical department and laundry, 24; and maintenance and housekeeping, 21.

It was felt not only that population growth and other pressures outside the hospital would force expansion but that changes in the age or nature of the population would indicate what sort of expansion was called for. A young, suburban community would

SURVEY COMMENTS PROVIDE FOOD FOR THOUGHT

The survey and the interviews that preceded it produced a variety of comments. Some applied to circumstances that were unique to the situations faced by the individual administrators. Some concerned concepts in hospital administration that are not universally accepted. Some involved ideas appropriate to the subject which are not expanded further in this section because of space limitations.

But all represent the considered opinions of thinking men and women on the subject of additions and convey ideas that could well be weighed by the hospital administrator.

Long-Range Planning

One of the architects interviewed says that he finds two major problems in planning additions to hospitals which do not have long-range plans:

1. The existing building has not been built with a strong enough base to accommodate an added vertical expansion of two or three times its present size.
2. If the base is structurally strong enough it is not large enough to permit inclusion in the addition of facilities now considered necessary, such as toilets for individual rooms.—Iowa.

Locating the Elements

The two architects advanced these rules on the subject of where to put what element in the addition:

"Get facilities like your kitchen, your laundry, and even your laboratory into a space that's more nearly square instead of a long rectangle. This generally works out more efficiently because you have less personnel travel from point to point in that department to do the same job."—Illinois

1. Eight to 10 floors is the maximum height for a hospital since further vertical expansion would cut down efficient elevator utilization.
2. Where possible, expansion should be vertical, however, since it makes for more economical plant operation.
3. Diagnostic and surgery facilities should be on the ground floor or in the basement, since expansion is easier and traffic is kept from the patient areas.
4. The maximum, and the best, nursing unit is 60 beds. This size enables the hospital to provide the professional nurse economically with the services and nonprofessional assistance she needs so that she can devote herself entirely to nursing.
5. The distance from the nursing station to the farthest bed should be 75 to 85 feet—with an absolute maximum of 90 feet.
6. The life of a building should be calculated at 75 years and additions should be built on to the newest structure in the existing plant.
7. All rooms should be designed for two-bed occupancy, despite the fact that in practice one-third of the rooms in a nursing unit will be used for private, single bed patients.—Iowa

"Operating rooms should be on the first floor; yet they are still on the top floor in some hospitals that are being built today—for no good reason. Furthermore, the surgical department should be in the 'fat' part of the building so that recovery rooms, central supply and other related departments can be located near by."—Illinois

"We have had considerable success with a two-bed room that could be made into two private rooms by folding doors."—Illinois

"Get rid of wooden floors. They are a fire hazard and create a housekeeping situation involving questions and sanitation, cleanliness and maintenance."—Illinois

Accidentally Cutting Services

Concerning the possibility that a contractor might inadvertently cut off a utility or interfere with hospital services, three widely separated administrators wrote as follows:

"The hospital should certainly provide for emergency service in case of extensive damage by making advance preparation for a tie-in to existing services."—Ohio

"The hospital should consider how and where new equipment will be stored pending installation and whether the hospital or the contractor is to be responsible for its storage."—Wisconsin

"I feel that in any addition to an existing building, the specs or contract should place the responsibility for utilities on the contractor."—Missouri

Planning for Fund Campaigns

Some administrators commented on the subject of fund raising campaigns:

"Personally, I'm firmly convinced that in any capital fund campaign involving over $100,000 the counsel and services of a professional fund organization are required. If a real need for expansion exists it becomes a matter of conveying the information to the community. Each fund counselor has his own methods of doing this, but essentially it all narrows down to getting a sizable number of the citizens 'involved' in the campaign. Perhaps the greatest benefit we received from professional fund counsel was to set the size of the corporate and individual gifts much higher than the figure any of us would have used."—Missouri

"Most of the criticism generated against expansion programs comes when the hospital decides to walk away from an existing plant, particularly when this involves moving the hospital to a completely new site. Even if the existing buildings are fit for storage use only, I still feel strongly that a hospital should not abandon its existing plant."—Iowa

call for enlarged obstetrical facilities, while a community in a resort or a rural area would require geriatrics facilities to accommodate retired people.

The survey bore this out. Forty-two per cent of the respondents specifically mentioned an increased load of older patients, and other replies would indicate that the percentage is actually much higher. Also, a surprisingly high number of those answering indicated that the community itself was demanding facilities for treatments not common when the hospital was built. The desire of the citizens to provide improved psychiatric care was cited by one administrator.

Despite this surprising emphasis on outside pressures, pressures from within the hospital were naturally more forceful in dictating what specific facilities were added.

The survey would indicate that administration's awareness of the continually increasing cost of operating was mentioned more often as a factor than the needs of the medical staff. Fifty-four per cent of the administrators said that poor facilities in old buildings were a factor, against 40 per cent who said medical staff needs were involved and 33 per cent who said that obsolete arrangement of facilities in old buildings was a factor.

NEW DESIGNS INCORPORATED

Changes in design and entirely new designs are being introduced by manufacturers of hospital equipment every year. This being the case, the hospital administrator planning an addition is faced with selecting equipment which often will change entirely the hospital's working procedure.

That the administrator happily takes advantage of this opportunity is indicated by the fact that 81 per cent of those queried listed anywhere from one to 27 items of new equipment that constituted, in their opinions, a major revision in their hospitals' working procedures.

The existence of brand new facilities next to old buildings occasionally creates a problem in patient and employe morale. Asked whether they had experienced any difficulty along this line 90 per cent of the administrators said they had not. Those who did said they overcame the difficulty quickly with orientation or by making some small concession to employes in the old wing.

Gifts and federal and state aid were mentioned as a source of funds for additions by 75 per cent of the hospitals queried. Only 21 per cent of the administrators said that a mortgage was involved and the same percentage said that a public campaign was necessary.

Forty-five per cent listed sources of income other than the foregoing. These included savings, reserve for depreciation, foundation grants and union health funds.

"If you had a fund raising campaign, is there a formula for selling the idea of expansion to the public which you found successful?," the administrators were asked. For the most part, the few who answered this question said that overcrowding over a long period proved the need better than any formula. One administrator noted that his efforts to sell an addition to his board were not hurt by the fact that a member of the board was installed in a bed in the hall of the hospital on one occasion.

If lenders of money have a different approach to hospital additions than to new construction, few of the administrators questioned had any problem because of it. Only 10 per cent were confronted with the fact that bankers generally prefer to finance new construction.

While only 33 per cent of those answering the questionnaire said that they experienced difficulty in their relations with the architect or contractor, the most positive, searching comments received involved this area of the additions building problem.

Also, of the 33 per cent who answered the final question of the questionnaire, which asked for any difficulty not covered concerning any part of the entire problem, nearly all went back to this aspect of things to watch for during the construction period.

Five questions were asked under this general heading:

1. In additions or remodeling it is important to take into account that the hospital must function during the construction. Did you have any difficulties along this line? If so, what?
2. Do you have any pointers on organizing hospital services during the period when the contractor is on the grounds? If so, what?
3. If the contractor inadvertently cut off a utility or interfered with a hospital service, who paid the cost of replacing it? Who was responsible for seeing that it was replaced?
4. In this light, if you were building another addition, are there any particular clauses that you would insist on having in the contract?
5. Is there any understanding with the contractor you would want to have, *i.e.* parking, eating in hospital cafeteria, and so on?

Regarding difficulties experienced in keeping the hospital functioning during the construction period, noise and dirt were the principal items mentioned. Interruption of food service was mentioned by two hospitals, and one administrator noted that his original plans to cope with the problem were stymied by changes in work and completion schedules.

Planning ahead and working closely with the contractor were the major pointers offered on organizing hospital services during the period the contractor is on the grounds. A practice highly recommended by those who adopted it was to have the chief engineer or chief of plant operations of the hospital work closely with the contractor.

Provision for the contingency that the contractor might inadvertently cut off a utility or a service apparently is written into most contracts. In most cases the contractor pays the cost and the architect or the contractor is responsible for seeing that the damage is repaired.

Clauses which would restrict the contractor and the architect, particularly clauses providing penalties for failure to meet completion dates, would be insisted upon in any future contract for additions to the hospitals queried. One administrator would ask that the architect have his plans completed well in advance to avoid delay in the work.

The contractor's men should not use the hospital parking lot, they should not eat in the hospital cafeteria, there should be a shack for the contractor's equipment, and provision should be made for storage, outside the hospital, of equipment waiting installation, according to those who answered the question concerning understandings they would want with the contractor.

OTHER DIFFICULTIES ENCOUNTERED

"Take a long vacation while it is being built" is the advice offered by one administrator, and anyone who has had the responsibility of conducting a hospital through an addition project would say "Amen" to that proposition.

Those who recognize that such a step would not be conducive to job longevity, however, recommend in summary that the administrator watch details, pick the architect carefully, set up a chain of command to handle changes, and, again watch details.

One administrator emphasized the difficulty he had in getting the last 2 per cent of the job completed, where subtrades had a few areas to finish up. This also was a problem where equipment was to be installed by the manufacturer, who in one case installed faulty equipment and in another redesigned the equipment and failed to inform the architect.

Two administrators noted instances where changes were made in specifications but everyone concerned was not notified of the change.

Round table included (from left, facing camera) Consultant Jones, Architects Hoenack and Erikson, Editor Cunningham and (from left, back to camera) Contractor Bulley, Administrator Zimmerman and Editor Robinson.

Good planning means good building

A Modern Hospital Round Table Group Considers Long-Term Planning, Old Buildings, Job Problems

AS POPULATIONS keep on growing, many of the nation's hospitals are planning additions or major remodeling projects to be undertaken this year or soon afterward; a survey reported last month by the American Hospital Association indicated that nearly half of all hospital buildings need modernization.

Administrators of hospitals whose additions have just been completed are likely to shudder and say, "Never again!" when asked what they would do differently if they had to go through another addition. But the fact is that most of them *will* build again, and again.

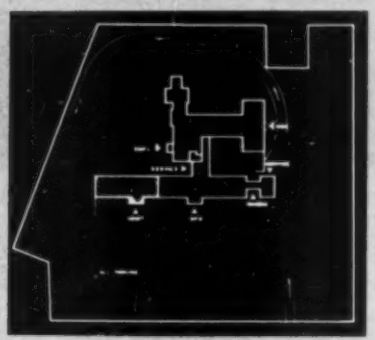
To help administrators and architects with hospital building projects ahead of them—whether it's their first or their tenth addition —THE MODERN HOSPITAL invited an experienced, authoritative group to come to its editorial offices recently to discuss all aspects of planning and building hospital additions.

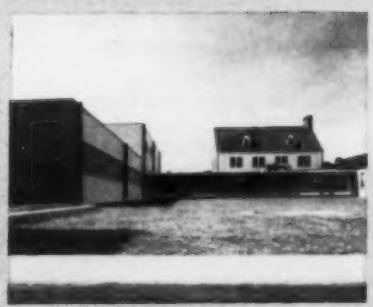
Taking part in the discussion were Everett W. Jones of Fort Myers Beach, Fla., hospital consultant; Carl Erikson Jr. of Chicago, a member of the architectural firm of Schmidt, Garden & Erikson; August Hoenack, chief, Architectural and Engineering Branch, Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C.; Mortimer W. Zimmerman, administrator of Louis A. Weiss Memorial Hospital, Chicago; and Allen Bulley of Chicago, a member of the firm of Bulley & Andrews, general contractors. Also present for the discussion were R. M. Cunningham Jr. and S. D. Robinson of The MODERN HOSPITAL editorial staff.

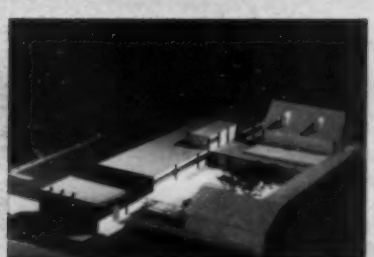
The entire discussion was recorded, and a transcript of it is presented in the following pages, condensed and edited to eliminate repetition.

Additions must anticipate community trends

Long range plan for Kent and Queen Anne's Hospital, Chestertown, Md., calls for integration of new and old facilities. Site plan (top) and architect's model (below) show how buildings will be grouped around central court. Photograph (center) shows old building at right and, in left foreground, new structure now occupied.







Expansion plan for Kent and Queen Anne's Hospital was worked out by Eshbach, Pullinger, Stevens & Bruder, Philadelphia architects, with hospital board, administrator and staff. "It is our feeling that in a 20 year expansion program the plan should not be so tight as not to allow for progress in medicine," the architect explained.

Cunningham: We did a survey of recent hospital additions (see page 68) as background for this discussion, and the first thing we asked was whether the hospitals had long-range plans, and they all dutifully said, "Oh, yes, of course!" Then we asked whether the projects they were engaged in now fit into those plans, and about half of them said, "No." So the first question is, "What good does it do to have a 25 year plan if it doesn't fit what you're actually doing?"

Jones: How many times when a client calls to begin to talk about an addition to an existing hospital do you find that the hospital really has any plan?

Erikson: Generally speaking, they aren't prepared at all. Most of them don't have comprehensive, long-range plans. Right now, we are working with several groups, doing nothing but developing long-range plans—in some instances where there isn't any actual construction contemplated in the immediate future. They don't want to do things today that are going to have to be done over again. Even with the smallest of our hospitals, we attempt to plan in such a way that without too much difficulty departments can be expanded.

Zimmerman: Well, I worry a little bit about this concept of long-term planning because, as I think back 25 years and think ahead 25 years in the hospital field, I'm not sure we even know what kind of communities we're going to have, much less what kind of hospitals and what kind of medicine. With my own board, we're willing to talk about 10 years. That's the kind of long-range planning we've been trying to do. We can get some intelligent projections on population shifts for the next 10 years, and we can get some intelligent projections of some of the technological advancements that may come about, but when you start to talk 25 years—either the hospital may become completely obsolete because of changes in medicine, or we may find that there is no community where we are. Sometimes this long-range planning doesn't work because we've tried to go too far.

Erikson: In the last 20 or 25 years the concept of patient care and the technics that have been developed in medicine and nursing which have brought about changes in the hospital building have been such that I feel trying to plan concretely for 25 years is almost an impossibility. But—particularly in the case of city hospitals, where land is at a premium—I think a determination of land usage has to be made. Now if you plan with that in mind—not what you're going to build but where you are going to build it—you know whether or not you should be planning land acquisition so you can pick it up when real estate values are favorable.

Hoenack: Of course, when you consider planning on a statewide basis the emphasis is a little different, but I think some long-range planning of specific facilities is essential. Whether it's for 10 years or 25 years varies with the type of community. Some communities are fairly static. Others are growing rapidly. But planning is essential. When we get right down to having to build, we may not build exactly what we planned 10 years ago, but that's nothing against long-range planning.

Bulley: We built seven additions to one hospital, and then it was wrecked—condemned for highway improvement. We worked for 10 years at another hospital that had a long-range program which was one of the best programs I ever saw. They're abandoning that hospital. One of the first hospitals we worked on, out on the south side of the city, has been abandoned. So sometimes these programs for additions to be made a few years afterward are a total loss. This is something that you can't foresee. But there are some signposts. For instance, we're pretty sure that we're going to see a growth of diagnostic and treatment outpatient facilities, not just for the indigent but for paying patients. Therefore we're pretty sure that when we lay out

any x-ray or laboratory department, and probably departments of physical medicine and rehabilitation, we'd better be certain that we can expand it without ripping the hospital apart.

Erikson: I have one hospital that was designed with the idea that it would have a maximum of 300 beds; the services and everything else were designed around that principle. It was completed about seven or eight years ago, and today we're rebuilding the entire service area—doubling the capacity of x-ray, laboratories, physical medicine, emergency department—and we're building them now on the ground floor so that if and when it's necessary to expand again we can build horizontally. If the present concept is changed and prepayment plans become inclusive as far as outpatient services are concerned, many more patients are going to be outpatients than inpatients, relative to the condition that exists today.

Jones: The whole trend toward locating doctors' offices either in or adjacent to hospitals means that more and more patients are going to be directed toward hospitals for professional outpatient work—x-ray, laboratory work and physical medicine. This means the capacity that we have to build into these departments has to be much greater than we thought 10 years ago.

Cunningham: Does this say something about where you locate these departments, as well as how big you make them?

Erikson: I think it definitely does. This is a good argument for taking the professional service departments out of the middle of the buildings, where we used to put them. We used to kill off any chance for expansion. I've seen a lot of new plans for hospitals recently, and most of them seem to be incorporating these areas on the fringes of the buildings, where they can be expanded more easily—particularly on the first floor, or even in separate wings.

Hoenack: There is a definite trend toward putting the diagnostic and clinical facilities on one floor, because you've got to think of remodeling later on. It also means we've got to use more air conditioning and artificial lighting, but it adds up to a better plan in the future if you should have to expand. Our experience in Hill-Burton has been that many hospitals that we approved four, five and six years ago are coming back for expansion of diagnostic and treatment areas. Years ago the hospital never wanted to do any outpatient work, because the doctors did it. Now that should be part of the long-range plan.

Zimmerman: I think some doctors appreciate that with the increasing complexity of clinical laboratory work, they aren't able to provide the kind of specialized services the patients need in their private office buildings, and they are a little more willing, now, to see patients referred to the hospital for this kind of workup.

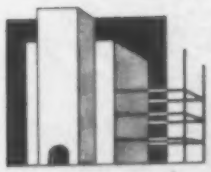
Cunningham: You aren't going to get a betatron in a doctor's office. But to what extent do you heed what the doctors have to say when you're planning the hospital facilities themselves—not just the diagnostic facilities, but the number of beds and operating rooms?

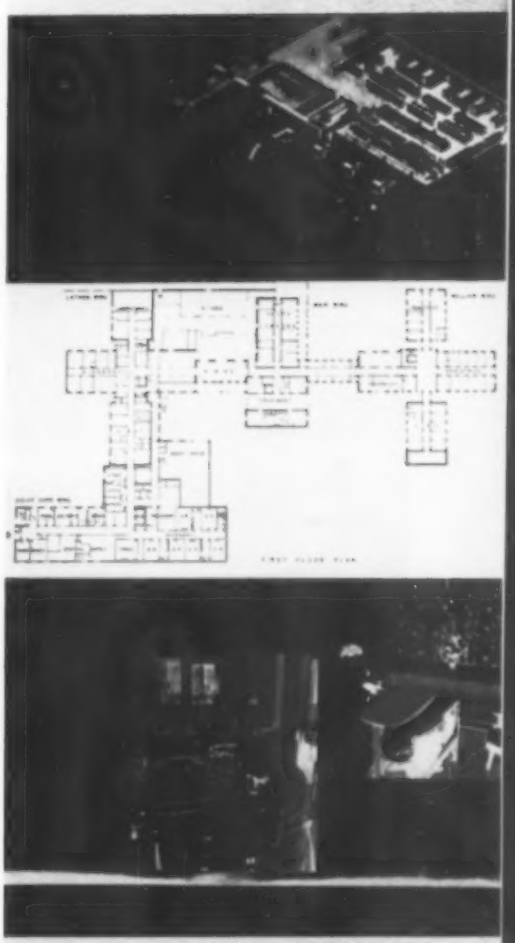
Zimmerman: I think they should play a very important rôle. The doctors have important decisions to make, not only in terms of what facilities are necessary but also what support they're going to give those facilities. I have doctors on my executive committee who are active all through the planning stages. They sit down with us and with the architects to discuss what we need, and where it might be located in the hospital building, and how it is going to be utilized. Then when we actually build the facilities, our utilization is good.

Erikson: I think one of the unfortunate things we are running into is that it is not uncommon to have the administrator become a block between the staff—I don't mean just the doctors, what I'm talking about is the nursing staff and other departmental heads—and the architects, so that the information we get is coming secondhand. Some of it we don't get at all, because the administrator doesn't feel that it should be given to us.

Cunningham: What kind of information?

Erikson: Departmental needs. Now we may be able to make an analysis of an area that indicates whether or not there is enough physical space for a given department. We may be able to determine





Linking old and new buildings in tandem style (see plan) has permitted orderly expansion at Decatur and Macon County Hospital, Decatur, Ill. Newest building in plan developed by Architect Dane D. Morgan, Consultant Herman Smith and Administrator Leon C. Pullen Jr. (lower left) is planned to permit of a vertical addition later.

that certain things should take place in that space, but if we don't have direct access to the people who are operating there, the technicians who are functioning in that department, we're not going to get the specific needs that make that department tick. And you'd be surprised how mad a group of nurses or doctors can get because they didn't have a chance to speak their pieces—and it makes us lousy, no-good architects!

Jones: I just saw a good example of that, on a job where the head nurses and the assistant head nurses sat around the table with the architect to help write a program for the nursing stations, before the architect put anything on paper. The way these assistant head nurses and head nurses discussed their relationships with the doctors who come up to work on records and to leave orders for medications and treatment was an eye-opener to me, and I've been studying nurses' stations for a long time. I learned a tremendous amount on this job, and so did everybody else!

Erikson: We have always taken the stand that a hospital is a personality. No two of them are alike, and the reason generally is the people who have made them what they are. You can't find out why Hospital A is a little different than Hospital B by talking to the administrator alone. You have to know the other personalities that are involved, and how the technics and the little peculiarities that each hospital has—how they grew up and why they grew up. Then you build into additions and alterations the reasons for that hospital ticking the way it ticks.

Jones: I suspect that there'd be fewer change orders when you get to building if more folks got together around the table before they ever put a line on a piece of paper!

Bulley: That is true. On the other hand, we had a sad example where the medical staff and the nursing staff all approved the plans, and the administrator had the doctors initial them. Before we were through he was being berated, and the architect was catching the devil. How could they ever have planned things the way they were? Finally the plans were brought out and the administrator asked, "Isn't this your signature?" Half the medical staff and four or five of the nursing staff had forgotten that they worked on the plan and approved it!

The administrator must match the requests of his department heads to the total space and money available for the additions project.

Zimmerman: I think you have to understand the problem the administrator faces when you're talking about an addition to an existing building. He's faced with a building program which has been limited from the beginning by the concept of the board of governors. They're willing to expand in a certain direction, or to spend a certain number of dollars for expansion, and the administrator knows that he can't meet everybody's desires. Of course, every department would like to have more room. It's his job to find out who *needs* more room. As a result the administrator may sometimes be unfortunately defensive about bringing people into the planning stage. He may feel, for example, that the physical therapist may have demands and requests far beyond his ability to satisfy in the program, and therefore he's going to defend himself by intercepting her before she gets to the architect. He's going to translate her need. This is wrong, very wrong.

Bulley: I think an administrator would be wise to do the same thing that this man I mentioned did—he had each one of them sign the plans.

Jones: I'd be willing to bet that the problem there arose because there was not enough free discussion and argument back and forth before they signed the plans. I've seen this happen. They all get feeling very agreeable, and nobody wants to argue, and before you know it they've put their initials on something that they've got some mental reservations about, or they put their initials on something they know nothing about, and there wasn't anybody around the table that knew enough about it to shoot penetrating questions and make them think.

I'll give you an example. I recently met with a group to study the needs of an x-ray department. The doctors had a lot of marvelous

Old building at Alameda Hospital, Alameda, Calif., was replaced by modern, two story structure with bridge to main hospital at left. New facilities planned by Stone, Mulloy, Marraccini and Patterson, architects, and George Collins, administrator, include diagnostic services, recovery room, central supply, pharmacy. "A master plan provides a framework for expansion of facilities with efficient operations insured at any stage," the architects and administrator explained.

ideas—how much space they needed, what they wanted. The trouble was that the amount of space they needed would have taken an entire floor of this hospital, and we had to get another department on that same floor! So we asked them to bring all their statistics to the next meeting—a record of the growth of each type of procedure in the department for the last 10 years. We asked them to split that up between ambulatory patients and inpatients. Those figures actually showed the doctors that they were asking for 50 per cent more space than they could possibly use in the next 50 years! They saw the point, and we came to a compromise.

Cunningham: Is there any similar kind of study or any group of facts that can be brought out to determine how many private, how many semiprivate, and how many ward beds?

Erikson: Third-party payments are putting a premium on the two-bed room, and this is pretty well setting the pattern for the present hospital.

Third-party payment systems put a premium on the two-bed room and enable many to demand single accommodations who otherwise couldn't.

Zimmerman: When my hospital was first opened we had 108 beds, each of which was in a two-bed accommodation. There were no private rooms and there were no wards. We knew that we'd have requests for private rooms, and we assumed that we had some flexibility and could remove a bed from a two-bed room. But of course the demand for beds was such that this wasn't a very desirable thing to do. So when we built the next four floors, which had been part of our original planning for expansion, we were able to make some modifications in the plan and get six private rooms on each floor. In order to determine how many private rooms we needed, we studied our statistics on utilization and requests for private rooms over a three-year period, and economic factors relating to the kind of people who came into our hospital. It worked out beautifully. It's a fairly objective thing to do, once you have some experience to go on.

Erikson: A hospital that has been functioning for 20 years ought to be able to tell within one room the type of accommodations that they should have. Furthermore, the way patient rooms can be designed today makes a difference. Semiprivate rooms can be designed for a lot more privacy than was possible in the old-fashioned two-bed room, where the patients' heads were within 18 inches of each other. We can design the room with the beds across the room from each other, or we can design them with modern folding doors. There are all sorts of things which we can use today to give maximum privacy in a semiprivate facility.

Jones: In a small or medium sized community, I think it would be pretty smart public relations to get the public in on helping you decide about private and semiprivate rooms. I'd want to find out what the citizens really want and what they think, and in a town of that size you can do it.

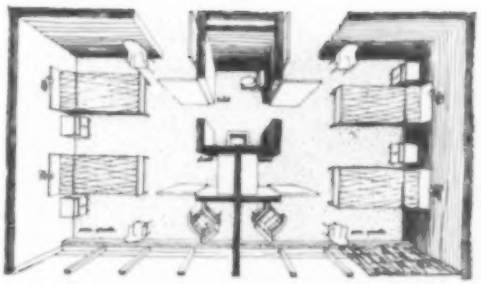
Erikson: Can it be done? I know if you were to sit down with me and ask what kind of accommodations I would want in a hospital, I would say I want my own private room. I would ignore the economic considerations at the time. But maybe when I actually went to the hospital I couldn't afford that private room.

Jones: Well, you can get what the people think, then you can check it with income factors in your town, and you can temper what they told you with the economic level of the people. I think it's important enough to go to all that trouble.

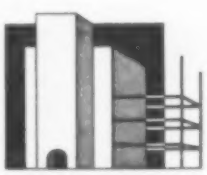
Zimmerman: The University of Chicago has done projections on population growth in the city by areas, types of population, income variations, nationality groups, ethnic groups and so on, and from these you can plot the kinds of hospital facilities that are going to be required in the next 10 years very simply.

Erikson: We use the population trend figures of the public service companies, and the telephone companies, because those outfits are generally trying to keep 10 years ahead of the population, and they are pretty shrewd at it.

(*Continued on Page 76*)

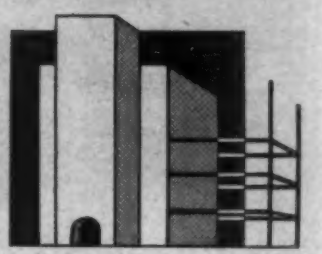


Third party payments have developed heavy demand for two-bed rooms; some hospitals have gone all out in planning, designed all patient accommodations for two-bed rooms, then had to shift gears to meet the demand for single rooms. Drawing here shows standard two-bed room designed by Eshbach, Pullinger, Stevens & Bruder for Kent and Queen Anne's Hospital, Chestertown, Md.



To Modernize Old Buildings or Let Them Go and Start All Over Again—That Is the Question

Old buildings can be saved if they're sound—but it may be too expensive



New and old styles go together at multiple-building hospitals like New York's Roosevelt (above) where Kiff, Colean, Voss & Souder have planted the new between two olds, and St. Vincent's in Birmingham, Ala., where Charles H. McCauley sought "a clean, simple expression that will not be in conflict with the original," as he said.

Cunningham: If you have a pretty good idea what the population projection is, and the need for specific facilities, the next thing you have to think about is what you've got now. Is there anything that can be said about the evaluation of existing plant that would be helpful? You've got a building here that was built in 1913, say, and another one that was built in 1929, and you've got to wrestle out this business of whether it's better to forget about this, or move things around, or start all over again. How do you sort out that kind of thing?

Jones: First, I would want to have a pretty good picture of what the mechanical maintenance cost on the old building is. If it's getting high and the building is obsolete, I'd better get rid of it. Then, what is the functional layout of the old buildings from the standpoint of reasonably economical use of employes' time? Again, if it's pretty bad, as it is in many old buildings, I had better get rid of that building or make a major rearrangement of it so that my employes' time is used more efficiently. Finally, I'd better consider whether or not my hospital intends to meet the standards of the Joint Commission on Accreditation of Hospitals. There may be a lot of surgery going on in this hospital that oughtn't to be going on, and if I intend to meet the commission standards I know the surgical load is bound to drop, which may affect my need for additional new operating rooms. The public is beginning to demand that hospitals be accredited, so I'd better find out something about that.

Hoenack: After an existing hospital knows pretty well, and it should know, what part of the medical care or hospital care needs of the community it can serve, and when we get down to programming for an addition, it seems to me the procedure should be pretty much the same as though it were going to be a new hospital. Too often, instead of fresh thinking as to what their needs really should be, hospital people think, "Now if we could only move this room down here and build something else there—." That kind of thinking stymies a good program, because they compromise before they even get started. Any remodeling and alterations and additions job is a compromise. We recognize that, but we can make a better compromise if we have a good program.

Jones: Sometimes remodeling an old building is as expensive, or more so, than if you started fresh and built a new hospital!

Hoenack: Very often that is the case. We've had many cases like that, where they felt that location of the hospital was important, and they were doing a good job in the neighborhood, and it was much better to do the job there than to give up and start over again somewhere else. We've had a number of instances where they could have built a new hospital, I'm sure, for what they spent on remodeling.

Bulley: I think in 50 per cent of the remodeling jobs we have done, we've felt that they've more or less thrown money out the window. In some cases, our workmen complain that they just put that wall up the year before, and now they have to take it down again! Alteration work is very, very expensive.

Zimmerman: I'm glad to hear the panel take this approach, because I thought I was a complete heretic. One of the tragic things in hospital construction is to see the number of old hospital buildings that we put up with. We do it over and over, because we're reluctant to junk a building which is still standing and still looks sturdy. I see

it happen all over the country. We've added to these old buildings, and we create so many problems. First of all, we spend more money doing this than if we started over, in many cases. We end up with a plant which isn't efficient, which uses more employes and more employes' time and is going to cost us more to operate over a period of years than the capital cost of a new building would have amounted to.

Jones: The trouble is that we don't sit down and write programs all the way through—not only for the new wing but for what is going to have to be done in the old buildings—and then get at the economics of this compared to starting fresh.

Erikson: What we are doing in every hospital today is study the rebuilding of services. What we've tried to do wherever it's feasible is to take *services* out of existing buildings and put those services in new buildings because it's cheaper to do that. If it's practical to recapture the old space for patient accommodations, you can do a good job on those reasonably economically, but you can't build new laboratories and x-ray departments and surgeries and birth rooms and nurseries in old buildings economically.

Cunningham: You said something as a general rule here that seems to me to be significant—that is, professional services go in new buildings and patient accommodations stay in old buildings.

Erikson: I say that only if the old building is a physically sound structure. Now if some of the piping has to be replaced, that's immaterial, but if the structure is sound, and many of them are sound, and if the general over-all plan is reasonably efficient, I think an old building can be used for patient accommodations economically.

Hoenack: The big question is, is it sound? That's where we have a lot of trouble. I don't think many people look at the building realistically in the beginning. It's a nice building and there's a sentimental attachment, perhaps. They really don't know how good the pipes are until they start adding some new services and pull down some of them. It's simple to test the piping. It should always be tested. If you have to replace pipes, that in itself isn't disastrous perhaps, but then you have to replace the plaster and flooring here and there, and then the new paint over replaced plaster doesn't look good, and we've seen cases where this goes on and on and on—this remodeling. Often it involves additional work which raises the cost tremendously.

Erikson: Take a hospital that was built 30 years ago. That building isn't an old building, and it should have been a well built building, but right off the bat you're faced with several things in a building that's 30 years old. In the first place, electrically it isn't adequate. Then it doesn't have much of the piping, such as oxygen piping, that a modern hospital should have. These things could be brought in. The electrical service can be brought from a substandard level up to an acceptable level without prohibitive cost, provided the rest of the building is sound. And if you take the laboratory and x-ray and other services and put them in the new building, you're going to tear into the old building so badly anyway that the fact that you're going to have to do some replastering and repacking, and that kind of thing, is not a major concern.

Jones: It's relatively easy, for instance, to bring oxygen piping into an old building without tearing everything down.

Cunningham: Would you think that any building with wooden floors is dispensable?

Bulley: You're dealing with a fire hazard before you get any further. They ought to be replaced, or else the building ought to be replaced.

Zimmerman: This 30 year old building still bothers me. Whether it should be remodeled or whether a completely new building might not be more economical and efficient in the long run ought to be considered very seriously. The entire heating system certainly is not up to date any longer and will have to be revamped completely if you're going to have a modern patient unit when you're through. We know a lot more about heating today. A lot of us want air conditioning in hospitals, too, and controlled climates which we can't

"Services in new buildings, patients in old" principle is followed at Decatur-Macon County, where two-bed room in photo above is in old building (at center of aerial view) and recovery room is in new building in foreground.

get unless we're willing to redo the system. Then we get into such things as pneumatic tube systems and other facilities which go through the heart of the building and are pretty expensive to put in an old building.

Erikson: Here you've got a building that's 30 years old, though. Thirty years ago that building cost you about $15 a square foot to build. The same building today is going to cost you somewhere in the neighborhood of $30 a square foot to replace. Now, let's assume that you have to put $10 a foot more into the building to bring it up to acceptable modern standards. How much more efficiency can you build into a new building to amortize that $5 a square foot? You're talking economics.

Zimmerman: I'd answer that by saying a tremendous amount—when I think of the cost of having a nurse walk an extra hundred feet for something time after time, day after day, 365 days a year!

Erikson: We all have to recognize the fact that there are many very poorly planned hospitals of that era. I am assuming a reasonably well planned unit, however, something that even today you'd consider reasonably efficient. I'm not talking about the buildings that were white elephants the day they opened the door.

Jones: I once saw some 1890, pavilion type, two-floor ward buildings for charity patients, where a nurse had to walk the whole length of the ward to do anything. Those wards were studied and relaid out, broken up into eight-bed units. An entirely new, two-pipe heating system was installed and handwashing facilities added at strategic locations, so no nurse had to walk more than 10 or 12 feet to draw water, empty water or wash her hands—procedures which are big time consumers. This was done in about 1936, when the building was 46 years old. But it was a very sound building to begin with and it was much cheaper to renovate those buildings than it was to replace them. The old wards are still there, operating very efficiently. There was a case where it paid to keep them.

Erikson: You can't always generalize. I've been involved in a number of alterations. Some of them were rather old buildings, and they turned out to be good from a structural standpoint. They had all the facilities. They may not have been too good functionally; you wouldn't design it that way now, but there was the building. It was an investment, and you can't ditch it.

We study a hospital program and determine with the staff and the administrator what is felt to be adequate space and what is felt to be the necessary departmental breakdown, and we locate things like x-ray, and the kitchen, and laundry, and other specific services. We then turn to manufacturers for specific, detailed recommendations pertaining to the departments.

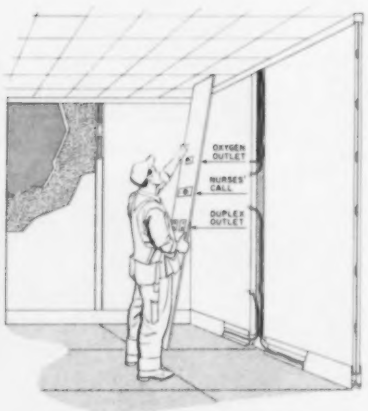
Zimmerman: The kitchen by and large is one of the worst planned areas in the average hospital. One of the reasons for this is that so many kitchens seem to be one person's brainchild. The dietitian comes up with a completely new approach that she's thought of all by herself, and this is the way she wants her kitchen. The administrator and the board go along with her, and the architect is told to design it in this fashion. It's a very specialized approach. Then she leaves the hospital three years later and nobody can make head or tail of that kitchen from that point on!

Erikson: You can't bring it back just to the kitchen. That goes for every department where you've got somebody with a screwball notion. If your architect isn't thoroughly capable and able to stand up on his hind legs and say, "This is basically wrong, and here's why," just what you're talking about happens. The radiologist goes out the door the day the hospital is finished; the pathologist goes to Keokuk; the chief surgeon retires and goes to Florida, and you've got an abortion on your hands!

Cunningham: No one-man plans!

Erikson: The architect is the outsider; he isn't going to have to live with these fellows. He's the one whose responsibility it should be to point out to the board, "Here are a lot of crazy notions that are going to be a mess!"

Prefabricated metal interior partitions installed at St. Alexis Hospital, Cleveland, substantially reduce maintenance costs, the cost of entering a wall to make utility repairs (done simply in the prefabricated unit as shown below) and the expense of moving partitions for relocations. George S. Rider Company were the architects here.



Problems on job can be avoided by planning

Detailed plans and tight supervision are needed to make certain work schedules go forward and hospital routines are not disrupted by building

Ground breaking and cornerstone ceremonies attended by both the dedicated and the curious foretell months of back- and sometimes heart-breaking toil for architect, contractor, administrator, staff. Work will be easier and problems fewer if plans, contracts and working arrangements are developed carefully and understood by everybody before the first spadeful is turned, experts make clear in these pages. Shown here are ground-breaking for addition to St. Francis Hospital, San Francisco (above), and cornerstone rites at St. Luke's Hospital, N.Y.

Cunningham: Well, you know we couldn't get any hospital people to admit in our survey of additions that they had a bad plan, but they all sang about what happened when they started to build! What can we tell people who are embarking on this kind of adventure? Let's assume they have beautiful plans and that everything is thought out. What can we tell them to do now to avoid trouble on the job?

Bulley: Seventy-five per cent of it can be avoided with a little thought and a little consideration. We remodeled the operating suite at St. Luke's over a week end. We had instructions to have it ready for an operation at 7 o'clock in the morning. It was a long week end; there was a holiday. Sunday afternoon none of the clean-up help showed up. We were all through, ready to leave the job, and the head nurse came in crying because all of her clean-up people had decided to take an extra day off. So we put our labor to work scrubbing up the room—and they operated the next morning at 7 o'clock. That's a little unusual, but in making a program you have to work with the administrator and with the people in the section you're working in. The man in charge on the job is my salesman as a general contractor; it's up to him to work with the administrator of the hospital and the head of the department that we are going to disrupt and explain to them what has to be done in order to accomplish what the hospital wants. He must give them sufficient notice of when we're going to start, how long we think it's going to take. If something comes up and it's impossible for them to interrupt their work, we expect them to let us know and ask us to adjust our schedule. We've had unusual conditions. We shut down one hospital for three weeks out here in the suburbs. We'd been given the contract to remodel and they told us we had three weeks. We had stockpiled all of the material; we had everything set, and we moved in. At one time, we had 14 plasterers on the job. We had 12 plumbers over the three-week period. We finished. The painter still had a little striping to do on the morning they were to move in, but they moved in. Their operation was held up a half hour because the doctors didn't think we would have it ready, and they had to call and tell them they were ready!

Jones: This means sitting down well in advance of the actual work and attempting to write a program, preferably on paper, so that everybody understands what it is you're going to do.

Bulley: But it's got to be flexible.

Erikson: We always attempt—particularly when we get into a contract problem with a lot of remodeling and rebuilding of departments —to set up a job procedure right in the general conditions of the specifications. The reason we do it is that usually the job procedure can cost the contractor a lot of money. We try to establish a pattern with you as the administrator, pointing out the problems that you're

going to be faced with so that you have a chance to think about it and tell us, "Well, now, couldn't we do something a little bit differently?" Then the contractor may figure, "Now if I can do a little juggling here, I'm going to make a more efficient operation for myself, and I don't think it's going to interfere with the hospital." In that case it's a matter of the three of us getting together and working out the best methods. At least it gives him a picture of what kind of work conditions he has to face.

Bulley: Another thing is the job meeting. Every week the architect has a job meeting with the contractor and subcontractors and a representative of the hospital. They're all there, and the discussion is immediately opened by the architect, who usually presides at the meeting, as to what is going to be done during the next week. If we say, "We're going to go into Room 414 and tear that wall out," and it happens that the big benefactor of the hospital is in Room 414, and is going to be there for two weeks, the hospital representative steps up and says, "Can we postpone that for two weeks?" We sit down and work it out. Everybody knows what's being done. We have a long-range schedule, but we don't make our actual plans until that meeting, and they are only for a week. And even those are subject to change.

Jones: Whose job is it to see that equipment which must be installed in a room or an area is, in fact, delivered and ready to install when you're ready to hook it up?

Bulley: Is the equipment being furnished by the hospital?

Jones: It might be furnished by the hospital. It might be furnished by the contractor. Let's take sterilizers, which must be moved into place and connected, and vents and insulation and a lot of other details have to be attended to. The hospital has made a separate contract with the manufacturer, but you're going to have to put it in. Now you have to notify the owners exactly, or reasonably precisely, when you are ready, don't you?

Erikson: It's *our* job to see to it that the material is available. If it's something that's being provided by the owner, the contractor will notify us that they're going to be ready to set those sterilizers at such and such a date. He wants the shop drawings, and he notifies us when he wants them.

"The architect should oversee delivery of equipment and should anticipate work schedules to avoid installation problems."

Jones: You, in turn, have to keep administration and purchasing alerted to be sure they get the equipment itself when he needs it.

Erikson: We generally have a prime contract on sterilizers, so that we have control of that. We notify the manufacturer that we have got to have the sterilizers on the job at a certain time, and he's got his shipping schedule on that basis. If they're not there, or if it's beginning to get close to the time when we need them, then the contractor will start shouting at me, or the steamfitter—whose responsibility it is to set the sterilizers. But that type of coordination is the rule. The architects should be responsible.

Jones: Recently, I saw a job where the sterilizers were sitting in crates out in a storeroom in the yard and the question came up, "Whose job is it to move the sterilizers up there so somebody else can hook them up?" This hadn't been put in the specifications, so the administrator had to go tell somebody, "You put them there—no matter whose job it is."

Erikson: That's the $64,000 question—whose job is it? We generally specify tailgate delivery, and it's the steamfitters' job to take it off the tailgate and move it into its final location. Once in a while you forget, and then you've got a hot one on your hands.

Jones: This is when the administrator has to step in and say, "You do it!"

Zimmerman: As a matter of fact, there were some jurisdictional disputes during our construction. The specifications call for some equipment to be connected by the steamfitter. But there's a dispute sometimes between the steamfitter and the general contractor as to who has the right to take this thing up.

Tidy hole in ground is work of Frank Trabucco at St. Francis, San Francisco (above). As work progresses on addition to Kennestone Hospital, Marietta, Ga. (below), empty spaces in parking lot indicate Architects Abreu & Robeson have kept workmen's cars away.

Jones: It is only the big cities that are highly unionized. This doesn't happen in the average town.

Zimmerman: Well, one of the problems we had with our original building, for example, was a dispute between the carpenters and sheet metal men about who was going to hang the cabinets. We had to stop work, and there were no cabinets hung while they fought this out between themselves. This happens in small towns, too.

Jones: I think as administrator I would settle that fast!

"A quick way for the administrator to foul a job is to inject himself into a jurisdictional dispute between unions."

Bulley: In Chicago, we do not have a great deal of trouble. We have a joint arbitration board, and a question of that kind is taken before the board and a decision is rendered, and you can get a decision on anything like that within three or four days.

Jones: That's a long time, sometimes—three or four days.

Bulley: It's not half as long as a strike, where everybody walks out. That happens. We are going through a similar situation on one of our jobs right now. This is going before the joint arbitration board. In the meantime, each union will participate in this work—this is also the carpenters and the sheet metal men—and so we have a carpenter and a sheet metal man doing what we normally had two carpenters doing, while waiting for a decision from the joint arbitration board to be handed down. They probably are meeting on it today. You could have had a strike there. If we had been bullheaded and said, "The carpenters are going to do it," then the sheet metal men and the pipefitters go off. If we'd said, "The sheet metal men do it," then the carpenters go off. The contractor is between the devil and the deep blue sea, and the owner is the one who catches it in the long run when your job is stopped.

Erikson: The quickest way you can get a job fouled up is for you, as the administrator, to inject yourself into something that there is a dispute about! You will get involved not only with that one trade but the whole kit and caboodle of them.

Zimmerman: What do you do when the contractor lets all his subcontracts, and the time comes for a subcontractor to come in. You call him up and tell him to come in, and he's tied up with so many jobs he doesn't know where he's going first—and he's holding up your whole job?

Bulley: That is generally the contractor's baby. In the first place, he had no business letting the contract to that man. Unfortunately, with public bidding, a contractor's hands are tied. The low bidder gets the job. If he's 50 cents lower, he gets the job. There is no consideration given to the very thing that you're talking about, or for the fact that in working on a hospital you are working on an entirely different type of building from any other building. Here you have a plumber, a steamfitter, an electrician, a ventilating man—all working on something that they have rarely figured at enough money for their work, because it's an entirely different operation from building an office building, or building a one-story factory.

"Leave decisions about subcontracts to men who are in a position to evaluate the subcontractor's ability to do the job economically."

Erikson: There are two ways of doing it, and I think there's a considerable difference of opinion among contractors as to which is the best way. We prefer to have a half dozen—maybe more, depending on the equipment list—prime contracts. We'll have the general contract. We may have a plumber-steamfitter-boiler contract all in one. We'll have a ventilating and air conditioning contract, and an electrical contract; an elevator contract; a kitchen equipment contract; laundry equipment, sterilizers—all prime contracts. It's our job to correlate those. We feel we can keep better control over the caliber of the contractors that way than we can by a single prime contract, because exactly what you're talking about oftentimes does happen, particularly where you have open bidding and anybody can take a whack at it. Contractors who are not too well versed in hospital construction and don't realize how complicated it gets are going to bid on

At Frank Cuneo Children's Hospital, Chicago, Architects Belli & Belli have completed steelwork on bridge which crosses street to connect the old hospital and new, modernistic building featuring patients' rooms which will connect to oval lounge.

price to get the job. Maybe their price is too low, and you don't have too much control over it. But, even there, we can control it. The general contractor has to submit all his subcontractors to us for approval. If we find that he is submitting subcontractors who in our opinion are incapable of doing their jobs, we can reject a name or make the general contractor present evidence to us that the man is capable of doing the work. Ordinarily, we ask the general contractor to state his own time, and then, of course, all the other trades are fitted into that. If he can do it within 350 days, for example, the rest of them can.

This view of addition under construction at St. Francis in San Francisco looks down new patients' corridor to spot where new and old buildings join; here the work schedules must be studied daily to avoid inconveniencing the patients.

Penalty clauses are easily written, but less easily enforced when extensions must be granted for weather or delay in materials.

Jones: Do you often have a penalty or premium clause for completion?

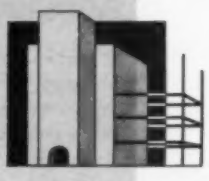
Erikson: We have a theoretical penalty providing damages if the contractor exceeds the time he has established, but that doesn't mean very much. All the contractor has to do is check the average weather reports for the area, and you've got 20 more days of rain this year than you had last year. Right away you have to extend the completion date by 20 days. Then you have delivery of material that's scheduled to be on the job at such and such a time, and didn't arrive until a month later—another extension.

Bulley: You skipped another very important point. Sometimes you submit shop drawings and don't get them back from the architect for two weeks! Then there are minor corrections, so you send them back to the subcontractor, and he returns them, and we resubmit them. They sit in the office, and they sit there and sit there. Then all of a sudden they are dug out and approved. In the meantime, anywhere from 10 days to three or four weeks have been wasted!

Erikson: There are so many ways to circumvent a penalty clause that I don't see there is any advantage gained for an owner by putting it in.

Cunningham: When these maneuvers are going on between the contractor and the architect, what *can* the hospital do to protect itself against delays?

Bulley: Sometimes that comes back to the hospital. Say we specify a Type C asphalt floor color range. So the asphalt tile man comes in and submits samples to the architect. The architect in turn sends them over to the owner. The owner gets them, and they've got to wait until they have a board meeting. They have the board meeting. Then, "Well, we ought to talk to Mrs. So-and-So, because she's going to be in charge of the decorating." By the time we get the samples approved, we've been waiting for that floor for months. Then that floor has to be ordered.



Many lengthy delays occur when the hospital staff cannot make a decision on some minor detail without approval of the board.

Erikson: Let me inject something else: Mrs. So-and-So didn't like that floor. She thought they were going to have a light-colored floor and this is a dark-colored floor, so it comes back to us. "We must have light-colored floors. This will never do!" What happens? We go back to the contractor and say, "How much more is it going to cost for this light-colored floor than what we specified?" He has to go back to the floor contractor. The floor contractor goes to the supplier. The supplier figures his price on that, comes to the contractor. He checks it over, comes to us, we submit it to the owner. Then the board meeting, which may be three weeks later, occurs.

Zimmerman: This is a very important point: The board must entrust to some one—whether it's the administrator or a committee—on-the-spot authority to make decisions. Otherwise the extra expense and delay become insupportable.

Erikson: You would be amazed at how many boards will not give the authority to any individual to approve an extra or a credit.

Bulley: In every specification and in every contract it says: "The contractor shall not proceed with any extra work or changes in his contract unless he receives a written order from the architect, okayed

by the owner." We have never had one given to us on the spot in the 35 years I've been in business! We've never had a written order brought out to the job saying, "We have this change," or "We want this." If we had waited for written notices, none of our buildings would be finished today!

Jones: Is this an indication of lack of understanding of proper organization on the part of the board, or is it an indication of the fact that the board doesn't have enough confidence in the chief executive officer to give him support?

Zimmerman: I think this arises from the fact that each member of the board and each member of the women's auxiliary suddenly becomes an expert in color and decoration and design and building. As a result, no one can advise them or make the decisions for them. The architect and the administrator should sit down with the board when first they talk about writing the contract, and they ought to tell the board, "If you want to save money—if you want this job done on time—you must make provision for on-the-spot decisions up to a certain limit, and you must give this authority to somebody who can make the decisions." In addition, the administrator should play an important rôle in supervision. He's too busy to be the clerk of the works, but I think that someone in his organization should be clerk of the works, if he has someone capable of doing it.

Erikson: I think that's fundamentally wrong, and here's why: Nobody in your hospital organization is capable of taking even a semi-unbiased attitude toward differences of opinion about interpretation of the contract documents. You as the owner are not always right. The contractor is not always right. If you have a person in your own organization establishing the correctness or incorrectness of something that's been done, or a decision that must be made, or an interpretation of something that could conceivably cost the contractor more money than he had anticipated, the contractor is going to take a very dim view of it.

One solution is to have a member of the hospital staff act as clerk of the works with full authority to make minor decisions.

Zimmerman: Let me clarify. The contract says that the architect is the arbiter of what the prints and drawing specifications show. The day-by-day decisions which have to be made on the job by the clerk of the works are mostly routine decisions—whether you prefer this kind of thing or that—the drawing doesn't show exactly. This man who's going to work with it is in a position to know.

Now we may get to a question that might cost the contractor some money. At this point, we get on the telephone and call up the architect and say, "Can you meet with us today?" We solve it that way.

Erikson: Do you have somebody on your staff capable of doing that?

Zimmerman: Yes. I have a chief engineer who has some construction experience, and I employed another engineer to take care of his routine duties and free him to do this job—almost on a full-time basis.

Hoenack: One of our problems in Hill-Burton is getting good supervision. An assistant administrator, someone who's been in the hospital normally, is the best one to do supervision on the job. If you do have someone who has been with the hospital, who can play that rôle, and happens to be an engineer, it may work out very well.

Zimmerman: With this system that I was suggesting, though, where you have your own representative as clerk of the works, the change order still must come through the architect, who must be kept informed currently of everything. But the day-by-day decisions can be made very adequately, when you have a trained person, by the person who is going to live with it. As a matter of fact, he's in a better position, I maintain, to know what the hospital needs.

Erikson: Suggestions for changes should come from the staff to the administrator, who sifts them to determine whether such changes are justifiable and why they weren't considered originally. Then, if a change is determined to be the thing to do, it is forwarded to the

Top photo shows surgical corridor under construction in addition to St. Francis Hospital. Photo below, taken a few months later, shows the same view as job was nearing completion in January this year. Crucial period occurs as job draws to close and delays seem inevitable, but the authorities say penalty clauses in contracts don't really mean much.

architect. If it requires drawings or changes in specifications, the architect makes such drawings and issues a bulletin to the contractor for him to get the prices that are involved. It's a kind of cumbersome process, but it's the only way that you can keep track of job costs, because in the case of many of these changes that are talked about, when they go to the contractor and come back, the price is such that it is economically impractical.

The reason these things happen is that people have trouble reading blueprints. There's no question about it; I read them day in and day out, and I still don't always visualize exactly what it turns out to be. So you can't expect people who look at one blueprint in their lives to visualize exactly what the thing is going to be. We try as hard as we can to describe it verbally. In some instances, we've taken a big room and cleaned it out of furniture and actually picked out on the floor where we've got to put the equipment.

"Suggestions for changes should go to the administrator, then to the architect, and then to the contractor for an estimate of costs."

Hoenack: The plans and specifications are really part of the contract, and can't be changed lightly. A lot of people don't quite realize that it should be changed formally. One device that we've been recommending is the preplanning conference, where the architect, and many of the staff, and the administrator, and others get together and discuss what their responsibilities are. The architect certainly should see all the department heads, but there must be someone to coordinate all this. Later on, there should be a preconstruction conference with the contractor and the various subcontractors, and all the other people responsible, to let them know what is involved in this particular job and to make sure that everyone understands the details.

Bulley: Can you do that on open, competitive bidding? After the low figure is in wherever any public money is involved, the low bidder gets the job. He may never have built a hospital; may never have seen one. He may not have money enough to do the job. He may not know how to do it. He may not have a competent superintendent to carry it through. Immediately the hospital starts to suffer, and the architect suffers, and everybody suffers.

Cunningham: This is not mandatory under Hill-Burton.

Bulley: It's mandatory wherever any government funds are involved—except in Hill-Burton.

Jones: One other thing I've got on my mind is the keeping of the premises where construction is going on—the grounds in and around the hospital where alterations are going on—clean, neat and safe, so that we haven't got tripping hazards, dropping hazards, explosion hazards, and fire hazards.

Cunningham: And no place for the doctors to park.

Bulley: A good contractor knows that he's got to police his job from an economic standpoint. If your job is sloppy, it's going to be inefficient and cost more money. The first thing to do is sit down and give the contractor an area for the storage of his material, for his offices, and for storage of workmen's cars—if you have it. If you haven't got it then the workmen have to find their own storage—not in the doctors' parking space!

Cunningham: Should this be in the contract?

Bulley: No, no. You sit down, talk it over and agree on it. Then the contractor works with the administrator. Often there are spots where things aren't the way they should be, so the administrator calls it to our attention. We remedy it immediately.

Jones: Are the contractor's men going to be allowed to eat in the hospital's cafeteria?

Erikson: I see no reason why they should be.

Bulley: We never have.

Jones: At any rate, it's something that should be thought of and discussed ahead of time. So is the use of hospital elevators by contractors' workmen, instead of an outside hoist.

Where new building is folded over old hospital as here at Memorial Hospital of Du Page County, Elmhurst, Ill., planned by Schmidt, Garden & Erikson, contractor must be especially careful to avoid problems caused by excessive noise.

Bottom photo, taken one month after photo at top, shows how materials pile up at job site as construction progresses. Consultants say: "The first thing to do is sit down and give the contractor an area for storage of his material, for offices, and for storage of the workmen's cars."

Cunningham: Can you have any kind of understanding about noise?

Zimmerman: This is a very important factor from the administrator's point of view. For example, we were putting a new roof on the building, which meant we were working right over the heads of patients, and there were certain hours we simply couldn't work. There were times when the contractor wanted to work evenings, but he couldn't work evenings where it was going to make noise, bother patients or interfere with sleep. This kind of thing should be part of the general agreement.

Jones: How about the workmen traipsing through various parts of the hospital where patients are and where things are going on?

Erikson: That's a matter of job control. If they haven't any business in the area, it's the job superintendent's detail to see that they don't turn up where they don't belong.

Jones: Here's another thing: Your workmen are going to bring their own lunches and they throw their empty bags and wax paper all over the place. Shouldn't some provision be made for trash receptacles, and shouldn't they be required to put it in there?

Bulley: You can have a trash receptacle for each workman, and you won't find more than one being used—much easier to throw it on the ground. That is a sore spot, and it's also a fire hazard. It is one of the worst things that we have to contend with. The contractor and job superintendent should cooperate 100 per cent and have a man police that.

The problems of noise, dirt, parking and eating on the part of the workmen can be solved by agreement with the job foreman.

Zimmerman: The contractor's superintendent on the job is really the key person. If he's the right man, this job will go well. If he's the wrong man, then everybody's going to be unhappy. He has to understand the hospital's special problems and be willing to work with them.

Hoenack: There are a lot of things the contractor sometimes can do to make it quieter—hanging tarpaulins, for example. It may take a little longer, but I think that's one of the things hospital people must recognize.

Erikson: One of the things that a good contractor realizes is that it's to his advantage to have good housekeeping on the job. He has a liability proposition. A poorly kept job is a job that is dangerous.

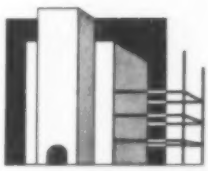
Bulley: Speaking of noise, we're doing a sizable alteration job, and there is a great deal of cutting that has to be done. We're using electric hammers. All during November and December we couldn't work certain hours, and at night we couldn't work. So now we have men up there with hand hammers. That costs a great deal more. On a contract job it should be specified that power hammers can or can't be used.

Zimmerman: How does it affect the kind of job you can deliver if the architect retains six or eight of the prime contracts, which are really out of your control then?

Bulley: I think the architect is inviting a lot of extra work that is not required. I think our relationship with all the subcontractors is very important. We need one thousand per cent cooperation on a building. I think we get it better and with less trouble ourselves than by having two people responsible for the cooperation.

Erikson: There is a lot of coordinating the general contractor can do, maybe better than the architect can do because he knows what his schedule is—when he's going to use certain things, so he doesn't have to go through the routine of having the architect's superintendent get hold of the steamfitter, or plumber, or whoever it happens to be. But I think there is also a material advantage in keeping control over the caliber of your mechanical trades. That's the only thing that I would say is to the owner's advantage in keeping control of the contracts.

Zimmerman: Then you would approve of a contractor having con-



Pictures show central supply room (top) and nurses' station in new surgical department at St. Francis. Delivery and installation of equipment, such as sterilizers shown here, can be tricky part of job, according to experts, especially if unions dispute jurisdictions governing tasks (see p. 81).

Photo sequence here shows ten months' work by Architects Schmidt, Garden & Erikson and Contractor Harry Verkler at Memorial Hospital, South Bend, Ind. When job changes follow orderly procedure, work proceeds according to schedule.

trol over all these, provided the architect has a veto right on the bid for the subcontracts? Is that correct?

Erikson: The architect has the authority to accept the bids of the mechanical contractors, which the general contractor would take over for a stipulated sum, or fee, to coordinate. Then the administration's job is expedited some, and at the same time you're keeping control of the caliber of these mechanical contractors.

Cunningham: One of our correspondents said he had just one suggestion for administrators: He said, "When you get to the point where you're going to start to build, either you run the hospital and hire somebody to supervise the building, or you take over the building and hire somebody to run the hospital. You can't do both!"

Zimmerman: If the administrator has any intention of putting in time on the construction at all, he has to make provision for delegating some of his regular duties. There's no question about that.

Cunningham: Which did you do?

Zimmerman: I compromised. I did some of both. It worked out very well.

"The administrator has no right to give instructions to a laborer employed by the contractor. He should follow procedure for changes."

Cunningham: Do architects find that too many administrators are trying to do both—trying to run the hospital *and* the building?

Erikson: These men walk around the job. They are not supposed to be telling the mechanics on the job what to do. The mechanics on the job are told by the contractor to take orders only from the superintendent. So the administrator doesn't have any authority. He's just an onlooker. If he sees something that he doesn't understand, or it looks wrong to him, then his procedure is to contact the architect's superintendent, who will either explain the situation or go look at it with the administrator. If there *is* something wrong, they can thrash it out. But the administrator has no authority to direct any of the contractor's men on the job to do anything—not even sweep the floor!

Bulley: On this job we just finished, I don't think our superintendent ever met the administrator of the hospital until they got ready to take it over. The assistant administrator came in about once every five or six weeks. That made for a perfect job!

Jones: If I were that administrator, I wouldn't regard that as ideal! I would want my man there all the time, to see what's going on!

Erikson: What do you have an architect for?

Jones: There are things that happen, and four or five brains are better than one brain, and I want my brains on that job!

Zimmerman: I've seen too many errors on blueprints that have passed by the architect, the draftsman and three other people. I can't blame them—there's too much detail on a blueprint to expect it to be 100 per cent perfect.

Jones: I'd like to see an architect tell me I haven't got any authority on my own job! Now, that doesn't mean that I've ever got the right to order a mechanic to do anything, nor have I got the right to order your superintendent to do anything, but I've got the right to go to the architect—and they're going to do something about it, or they're going to get off the job!

Erikson: I said just exactly that. I told you how you would proceed. You're spending the money.

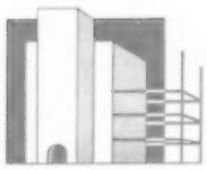
Jones: You mustn't say the administrator has no authority.

Cunningham: He means you have no direct authority over his workmen.

Zimmerman: Everything should be in writing.

Erikson: As much of it as possible, so there is no misunderstanding.

Bulley: There is not one owner in a hundred who hasn't always wanted to build. Now he's going to build a new building, and he will be very happy to assist the general contractor! That is the most difficult thing in our business!



Programming is a necessary first step

The Administrator Obtains a New Insight As an Incidental Dividend of a Step-by-Step Survey of Departmental Operations

E. TODD WHEELER

AS A preliminary to planning, the preparation of a written program for a new or expanded building is essential. The process compels analysis of the functional needs of the hospital; it brings the administrator and his department heads together in the planning process, and it instructs the architect as to the specific requirements of the project. During the preparation of preliminary plans for the building itself, the program serves as a useful checklist to make sure that all needed elements have been provided for.

The functional program describing departmental operations and needs, as distinct from the architectural program, should include at least three categories of information. First is a list of the persons who will be working in each department; second should be a fairly detailed description of what they will be doing, and third an indication of the major items of equipment they will need to perform their functions.

Sometimes the description of work and equipment needs is quite simple, as in the case of a clerk who will be typing and needs only a typewriter and desk. More often it becomes complex, as with a laboratory technician, who may perform many procedures involving a variety of equipment items.

In describing work patterns, the program also indicates the essential functional relationships between the department described and other parts of the hospital. Later, the architectural program—usually prepared by the architect, with assistance from the consultant and the administrator—will list all rooms and other facilities which must be provided in the new building, including an outline of structure and finishes. Together, the functional and architectural programs furnish the information from which the architect can begin his preparation of preliminary plans for the building itself.

In addition to the information provided by the functional program, there are other benefits to careful programming generally unforeseen, which the alert administrator can use to advantage. This is especially true in projects involving modernization and expansion of existing hospital facilities; thoughtful preparation of the functional program forces the administrator to make studies that not only contribute to the program but often reveal potential operating improvements.

The method of approach is important. The deficiencies of the existing hospital are usually well known to the administrator, but they should be listed by departments, nevertheless, for detailed review. Certain other deficiencies can be revealed by department heads; still others by means of inspections by the architects and engineers. The most effective method is for the architect and the administrator to inspect each department, both with and without the department head. This kind of inspection rarely fails to reveal many unknown—and sometimes surprising—facts. The architect should also appraise each department for its size, arrangement and equipment, according to recognized planning standards. He should ask questions of department heads and others, particularly on points which appear to be substandard. A careful and persistent review, followed by discussions between architect and administrator, will pay direct dividends in planning for the addition and modernization project.

It also pays indirect dividends, of which the most obvious is increased

Recently rejoining the firm he left in 1944, Mr. Wheeler is hospital and medical education specialist for E. Todd Wheeler and Perkins and Will, Chicago architects. Since 1941 he has served as a consultant in planning more than 70 hospitals, medical schools, medical education centers and labor union health and welfare facilities. In addition, he has served in several capacities with the University of Illinois, Chicago branches; as director of planning of the Chicago (West Side) Medical Center Commission, and as assistant to the Illinois state architect.

knowledge by the administrator of what is being done in his hospital. He may find that some departments have pressing needs which should be met at once, or that space currently assigned to a department is not efficiently used. One of the interesting things about space is that for some reason the right to use space in a hospital is considered almost more important than the number of persons on a departmental payroll. Both are presumed to be a measure of the department's importance—and hence the corresponding importance of the department head. This is especially true if teaching and research are carried on to any extent. An incidental dividend of the detailed space use analysis which the architect should make as a part of planning the expansion may be the discovery of some space which could be used more efficiently.

Such a study in one teaching hospital, for example, revealed two rooms which were seldom observed to be in use. The department head insisted they were used for research by the residents and by a graduate fellow, and could not possibly be released. The administrator could not refute this claim, though the evidence appeared to be to the contrary. After waiting a month he instructed the housekeeper to discontinue cleaning these rooms, to dust a little flour on the floor at the door to each and to unlock the doors every night to see if any one had walked into the rooms. It was almost three weeks before the first footprints appeared, and another 10 days before it happened again! Armed with this information, and with findings from the planning study to support him, the administrator held a discussion with the department head. The result was that one of the two rooms was released for other purposes—and a lagging research program was stimulated!

Inspection by the administrator and architect and the designation of a plan for the actual use of each room sometimes reveal interesting facts about storage of supplies, especially in little used spaces. For example, many hospitals have operating rooms with adjoining viewing galleries which, for one reason or another, are no longer used. They are generally above the corridor leading to the operating room, or on the floor above. Thus the front row of the gallery is high enough for its floor to be concealed from the view of those in the operating room, and here is where it appears handy to store extra bundles of linen or additional stand-by boxes of surgical supplies. In one hospital the administrator went from operating room to operating room and found four galleries stacked with linen and supplies. In another hospital there were supplies underneath the gallery steps, which had been built of wood, like a grandstand, as well as on them. True, the other side of this story may have been that there was a great shortage of storage space, and perhaps the galleries should have been removed and made into storage rooms, but a question was raised about the need for as much stand-by stock as was found, and also about its condition for surgical use. At the very least, the need for surgical suite storage was emphasized and was sure to get into the program.

An analysis of the department of general stores and of the storage space available in any hospital almost invariably shows two things—first, that there are a number of separate storage spaces for new goods, which inevitably means a higher inventory than would otherwise be necessary, and, second, that space intended and needed for storage has slowly been preempted for other, allegedly more urgent, uses, often forcing storage into outhouses, attics and cellars. Now it may be said about storage space that the least you can get by with is the best amount, because goods that are not used or seldom used should be disposed of, and not stored, and the smallest safe inventory is the best. But if there are 37 separate storage spaces, all supposedly active, as were found in one large teaching hospital, it would be a rare storekeeper who would be able to weed out the discards regularly. If inspection were to reveal ways to eliminate even a quarter of that number of storerooms, hospital operations would gain in efficiency. The programming of space offers an excellent, and impersonal, opportunity to study this problem.

REVIEW OPERATING METHODS

Program analysis also opens the way for objective review of the operating methods being used. In one hospital an inspection of central sterile supply showed that the surgical workroom had gradually taken over many of the functions of sterile supply because the service given in C.S.S. had not been satisfactory. In this case, a special dumb-waiter connecting the two suites was no longer used because there was no way for members of the operating room staff to give verbal instructions except by going down the hall to the phone in the supervisor's office, a busy place, and even when the call went through, the girls in C.S.S. didn't always get things straight. So the dumb-waiter was being used for storage. Of course, these are matters which might have been cared for routinely and administratively—but they were brought to light by space use inspection, and by questions about functional programming requirements.

In programming for modernization and expansion, an effort is usually made to upgrade existing nursing stations to make them as efficient as the new ones. The study necessary in planning this reorganization of nursing stations often reveals improvements which are immediately possible in nursing methods, or in nursing station facilities, without waiting for the total project to be completed. Every such improvement saves nursing hours or permits better patient care than before. The mere listing of the beds served by each nursing station may call to the attention of the administrator some problems of nursing unit size, or of distance from station to bed, which suggest a reassignment of rooms. This process usually reveals deficiencies in the supporting rooms—such as examining and treatment rooms, medication space, charting space, solariums, nurses' toilet, storage and even utility rooms. It is seldom that space can be found for these functions except at the sacrifice of beds, but study does emphasize the need for them to be included in the programming for new quarters.

Often the programming of employes' facilities reveals deplorable locker and toilet accommodations presently in use, and sometimes these can be improved temporarily, or at best the worst deficiencies can be removed.

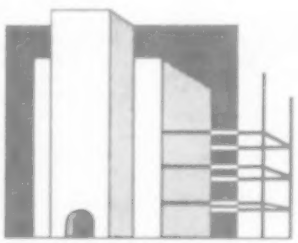
Another important and generally unknown area in which program study often uncovers many inconsistencies is in the provision of stand-by and safety equipment such as pumps, generators, storage tanks, boilers, valves and transformers. The architect and engineers should study these needs carefully, report hazardous deficiencies, and plan for the necessary minimum of such facilities. It will pay to ask, as part of the inspection, how often such stand-by equipment is used or tested, and what evidence there is of true need. Sizable amounts of capital may be tied up in such equipment, so careful study is certainly justified. Fire and safety hazards also need analysis and correction following inspections. Outside the hospital building, a review of needs for automobile parking space may reveal some better ways to use space and result in reassignment of parking areas. Similarly, a review of the utilization of ambulance and service entrances may be worth while.

The programming of a food service department for a new addition can also pay dividends. In one hospital this resulted in the discovery that labor costs per meal were three times the average in other hospitals, while

material costs were average. The food was superior and the service was without peer. Study revealed how distribution costs could be reduced without lowering quality and the hospital elected to make a change in its food service system. Steps were taken to set up a trial run long before the new system would be needed for the full load. Thus programming early in the project allowed time for trial and decision without costly delay or risk of mistakes. In another hospital the programming study of food service showed that a major complaint against the existing system was that patients' trays sometimes arrived before the patients had been made ready. In this case the tray was left on the bedside table, and the patient could then watch the food cool while he waited for the nurse to crank up his bed. Dietary personnel served the meal but could not prepare the patient. This situation was corrected by having a nurse's aide check all patients just before serving time and give instructions to the maids on any patients who were not to be served. Such a problem seems simple enough, but in this case it took the jogging from the program study to bring about the corrective measures.

INSPECT EACH DEPARTMENT

These cases demonstrate that inspection by the administrator and architect regarding space requirements is bound to reveal operating problems. Of course, a superficial inspection will not solve these problems, but there is a way to get at them with each department head—by scheduling a second, more painstaking inspection of each department by the administrator, the architect, and the department head. This inspection should produce a list of desirable improvements, both of facilities and of methods. It also offers an excellent opportunity for the administrator to review departmental procedures and performance for the purpose of understanding how to plan for an improved and expanded new department, and this process in fact often suggests ways for improving the present operation. Such a review need not await the building project to stimulate it but there is no doubt that plans for building do stimulate such studies. In addition, they permit reviews of operations without any implied criticism of existing personnel. If faults are found, the face-saving point may be made that in planning for a new department all possible shortcomings of existing operations, resulting presumably from inadequate facilities, should be eliminated. This method will be found especially valuable for departments concerned with goods and services and only indirectly involved in patient care. A thorough restudy of the whole process of ordering, receiving, storing, preparing and distributing food can be initiated, incidental to programming the expanded kitchen and the new floor pantries. Similarly with linen handling, housekeeping procedures, and central sterile supply. In general stores, the existing inventory of goods should be appraised to see whether it is too large or too small for efficient operation, quite aside from space limitations. The floor space used and intensity of use should be measured, and the desirable inventory and floor space calculated for the projected plan. In the process there may be flow studies of goods which will also help in appraising existing methods of distribution. It is not often that time can be taken for basic research on materials and methods, yet that is exactly what is most needed in determining the functional program. For example, is the method of linen distribution, or even just the linen cart, up to date? Could the flow of food through the present kitchen be improved? How about storage of volatile liquids? Is central sterile supply adequately serving its users? Is procurement being done efficiently? Basic policy decisions on methods of operation in all these departments must be made or reaffirmed before intelligent planning can be done for new and expanded facilities. It may seem elementary, but it not infrequently happens that the administrator in studying the functioning and the facilities of his departments finds ideas among his department heads. Conversely, the process opens the door for the administrator to practice leadership in getting his people to think for themselves about new methods and about improvements in old methods of doing tasks.



Not the least of the benefits of careful programming of building needs is the boost to morale when staff members come to realize that better things are ahead and that they had a hand in planning the program.

Moreover, such a review almost always results in fairly extensive house cleaning, the elimination of unintentional hoarding, some reduction of inventory, and the improvement of staff morale. A good janitor would rather clean out an accumulation of junk than clean around it week after week.

Certainly a great benefit comes from participation of many staff members in the reviewing and programming process, and this is essential to the successful building plan. In this process the administrator will gain valuable experience in holding back the more aggressive department heads and encouraging the timid ones so as to achieve an equitable assignment of space. Such control is part of the leadership which can come only from him, and the administrator himself may thus benefit from the discipline of being forced to learn about his hospital operations from a point of view not customarily his. He becomes conscious of the cost, and the value, of floor space. He thinks of materials in terms of maintenance, durability, color and texture, as well as function. He has an incentive to do some personal research on problems of planning as well as operations, and inevitably he learns something which will improve his administration in the hospital.

MAY FIND NEW SOLUTIONS

Additional dividends appear when the programming reaches the point of being translated into preliminary plans. Then the administrator finds that his knowledge of function and his desire for economy may often combine to produce solutions new to him and perhaps original in the field. This same updating of thinking will appear among department heads as well, and in fact with most personnel who have a hand in the planning.

Not the least of the benefits of careful programming of building needs is the boost to morale when staff members come to realize that better things are ahead and that they are to have a hand in planning them. However, if planning has been careless and has promised more at some point than the budget will permit, the effect on morale will be correspondingly bad.

Needless to say, the benefits of programming do not come without effort, but if the planning team and the administrator, particularly, put forth the effort needed to produce a thoughtful and comprehensive program, and if the administrator keeps his eyes open for improvements, there is no reason he should not realize all these dividends, plus many more of his own discovery.

SURGERY, CENTRAL SERVICE, RECOVERY ROOM

Sooner or later in the building program of the addition, the specific needs of the various departments must be reviewed. At this stage, detailed checklists of the functions and needs of the departments will prove particularly helpful. Such a checklist has been prepared by the staff of the Washington State Department of Health. Portions of it are reprinted here.

SURGERY SUITE

Determination of the Number of Operating Rooms

Questions to be considered when determining the number and types of operating rooms include:

1. What is the estimated number of surgeons on the hospital staff who will be using the surgery suite—by service and by specialty?

2. Will the operating rooms be reserved for certain specialty surgery?

3. How many surgeons from each surgical service or specialty group will be operating daily?

4. What is the average length of time for an operative procedure by service or surgical specialty?

5. What will be the program for scheduling operations? (a) How many days of the week will surgery regularly be scheduled? (b) How many hours a day will surgery regularly be scheduled? (c) Will certain rooms be reserved for certain specialty surgery on some days?

6. What is the average number and kind of emergency operations that may be performed daily?

7. Will the operating rooms be used for any "outpatient" surgery?

8. How many anesthesiologists and nurse anesthetists will be on the staff?

9. Are any research programs planned?

Under whose nursing supervision (surgical nursing supervisor, surgery supervisor, or separate recovery room nursing supervisor) is the recovery room or intensive therapy service to be placed?

Under whose medical supervision is the recovery room or intensive therapy service to be placed?

In which area of the hospital should the recovery room or intensive therapy service be located?

Checklist

1. How many preoperative hand-scrub areas are to be provided?
   Where are these "scrub" facilities to be located?
   How many persons are to be accommodated in each "scrub" area?
2. Should extra provisions be made for any types of specialty surgery? In what rooms would such provisions be required?
3. What x-ray services will be required in the surgery suite by service or type of operation?
4. In how many rooms will x-ray service be required?
5. What provision will be necessary for the use of radioactive materials in the surgery suite?
6. What provisions will be necessary for pathological or bacteriological services?
7. Should provision be made for such services as electrocardiography or encephalography within the surgery?
8. Should provision be made for televising surgical procedures?
9. Are any special facilities for research purposes needed within the surgery suite?
10. What provisions should be made for storage of blood, a bone bank, eye bank, and arterial graft materials?
11. What provisions for oxygen, suction, nitrous oxide, and air pressure are to be made within the surgery suite? In what rooms should these provisions be made?
12. Are interval-timers on clocks needed in the surgery suite? If so, in what rooms?
13. What provisions are necessary to avoid anesthetic explosions and shock hazards?
14. What will be the procedure for transporting patients to surgery? Who will be responsible for the transport of patients?
    What will be the procedure for checking patients within the surgery suite prior to an operation? Where will this be carried out?
    Where will patients be transferred to the operating tables?
    What provisions are necessary for preparing patients for anesthesia and surgery?
    Are separate rooms for waiting, transfer of patients to the operating table, preparation of patients, or anesthesia induction needed?
15. What postoperative care will be given to patients within the surgery suite?
16. What is the estimated quantity of anesthesia supplies and equipment for which storage must be provided? (Itemize.)
    Will all storage of anesthesia supplies and equipment be centralized in one room or area, or will there be some decentralization of such storage so that storage facilities should be provided in several rooms or areas?
    What will be the procedure for the cleaning of anesthesia equipment and who will be responsible for the cleaning of such equipment?
    What facilities will be needed for the preparation, cleaning and storage of anesthesia supplies and equipment and where should these be located within the surgery suite?
17. What is the estimated quantity of drugs for which storage must be provided within the surgery suite?
    What facilities are needed for the storage and preparation of medications?
18. What is the approximate number of flasks of parenteral solutions for which storage must regularly be provided within the surgery suite?
    Will the storage of parenteral solutions be centralized in one area or should storage space for these solutions be decentralized? If decentralized, in what rooms should storage be provided?
19. What provisions should be made for sterile water within the surgery suite—flask system or water sterilizers?
    If the flask system is to be used, what is the estimated number of flasks for which storage must be provided?
    What facilities are required for heating and storing solutions? In what rooms should these facilities be provided?
20. What practices and procedures are to be observed in the processing and storage of surgical instruments?
    (a) Will surgical instruments for each operating room or surgical specialty be cleaned and stored separately?
    (b) Will instruments be picked and sterilized (unwrapped) before each operation? Or, will instruments be wrapped and sterilized in advance for an entire day's operative schedule? If so, will this be a responsibility of surgery or central service?
    (c) What routine procedure will be followed for the collection, cleaning and sterilizing of instruments after each surgical procedure?
    (d) What procedure will be followed for the collection, cleaning and sterilizing of instruments following a surgical procedure for a septic case?
    (e) What provision should be made for the emergency cleaning and sterilizing of instruments?
    What is the estimated inventory of surgical instruments for which storage must be provided in the surgery?
    What facilities will be needed within the surgical suite to carry out the plan for cleaning, sterilizing and storage of surgical instruments?
21. What cleaning, packaging and sterilizing of other supply or equipment items (gloves, packs, sutures, diagnostic instruments, and so on) will be carried out within the surgery suite?
    What facilities are required to carry out this work?
22. What is the estimated quantity of sterile supplies and equipment for which storage must be provided within the surgery suite? (Itemize.)
    Will the storage of sterile items be centralized or decentralized within the surgery suite?
    What storage facilities are needed for sterile items and where should these be located?
23. What is the estimated quantity of clean surgical supplies and small equipment for which storage must be provided within the surgery suite (such as bandage, tape)? (Itemize.)
    Will the storage of these clean surgical supply and equipment items be centralized or decentralized within the surgery suite?
    What storage facilities are needed for these clean surgical and equipment items and where should they be located?
24. What provisions are necessary for the storage of large equip-

ment used within the surgery suite (stretchers, solution standards, extra tables, orthopedic equipment, cauteries, and so on)? (Itemize equipment.)

25. What will be the procedure for the storage and distribution of linen within the surgery suite (gowns, masks, sheets)?

What will be the procedure for collecting and sending soiled linen to the laundry?

What is the estimated quantity of clean blankets and pillows that must be stored within the surgery suite?

What will be the procedure for collecting and sending soiled blankets and pillows to the laundry?

What facilities are needed in the surgery suite for handling clean and soiled linen, pillows and blankets as planned?

26. What procedure will be followed for the "take-down," cleaning and care of an operating room following each surgical operation? Who will be responsible for this "take-down" and cleaning?

What procedures are to be followed for the "take-down," cleaning and care of an operating room following a surgical procedure for a septic case? Who will be responsible for this "take-down" and cleaning?

What practices are to be observed in a daily, thorough cleaning of operating rooms? Who will be responsible for this cleaning?

What facilities will be needed to carry out the cleaning of operating rooms as planned?

27. What will be the procedures for the collection and disposal of all types of waste: (a) general waste, (b) surgical waste, (c) liquid waste, (d) plaster from the surgery suite?

What will be the procedure for the cleaning of corridors, service rooms, and personnel facilities within the surgery suite? Who will be responsible for this cleaning?

What is the estimated quantity of housekeeping supplies and equipment for which storage must be provided within the surgery suite? (Itemize.)

What facilities should be provided within the surgery suite to carry out general housekeeping in the suite as planned?

28. Will the operating suite have a secretary?

29. Where are telephones, paging speakers, or other communication facilities to be located within the surgery suite?

30. What provision should be made for clinical and administrative record procedures?

What charting and dictating areas are to be provided within the surgery suite?

What is the maximum number of persons for whom space should be provided in each charting and dictating area (secretary, surgeons, anesthesiologist, anesthetists, nurses)?

What is the estimated quantity of administrative and clerical supplies and equipment that must be kept in the surgery suite? (Itemize.)

What facilities must be provided for the storage and use of such supplies and equipment?

Is a surgery schedule board to be provided? If so, where should this be located?

31. What is the anticipated maximum number of staff who may be working within the surgery suite at one time (surgeons, anesthesiologists, anesthetists, dentists, resident medical staff, nurses, technicians, clerical personnel, housekeeping personnel, students)?

What personnel facilities are to be provided for staff in the surgery suite (locker rooms, lounges, toilets, showers)?

What provisions are to be made for serving food or beverages to the staff of the surgery suite?

32. What offices are to be provided the staff (surgeons, anesthesiologists, nursing supervisor, instructors) of the surgery suite?

33. What provisions are to be made for conference space for nursing and medical staff?

34. What provisions are to be made for books and other reference materials within the surgery suite?

35. What provisions are necessary for visiting physicians, dentists, nurses and other professional persons to observe surgical operations in connection with professional meetings or educational programs?

What is the maximum number of persons who would be observing at one time?

What facilities must be provided for such visitors (galleries, lockers, toilets)?

36. Are classrooms for personnel or students to be provided within the surgery suite?

CENTRAL SERVICE

Determination of Services

The central service department (commonly called "central supply") is a department which processes, issues, and controls medical supplies and equipment, both sterile and unsterile, to other departments of the hospital. A central service department offers an opportunity to bring about standardization and coordination of materials and procedures.

The functions of the central service department should be carefully analyzed early in the planning as these will affect the utility areas, storage areas, and sterilization equipment throughout the remainder of the hospital.

1. What broad categories of supplies and equipment are to be provided by central supply?

2. What expendable items will be issued through central supply?

3. Will all preparation and distribution of sterile supplies (including surgery and OB packs and instruments) be the responsibility of central supply?

4. Will flasked solutions for surgical, obstetrical and other procedures be prepared in central supply?

5. What equipment for patient care is to be maintained and issued by the central supply?

6. Will patients' bedside utensils be sanitized (or sterilized) in central supply?

Checklist

The services to be provided by the central service will have been determined early in the programming of the hospital.

1. What items will be purchased ready-made (such as surgical dressings, parenteral solutions, disposable parenteral sets, and other disposable items)?

2. Will any preparation of materials take place in other departments (such as folding of linen for packs in laundry, washing of gloves in laundry)?

3. What sterilizing equipment will be available in other areas of the hospital?

4. What method will be used for distributing supplies and equipment to each of the other departments to be served:

Surgery suite	Laboratory
Delivery suite	Pharmacy
Nursing units	X-ray
Nursery	Outpatient department
Emergency	Housekeeping
Physical therapy	Other

5. How many hours per day will the central service be staffed and open for receiving and distributing supplies and equipment?

6. How frequently will supplies and equipment be delivered to and from other departments?

7. What provision is necessary for emergency delivery of supplies and equipment to other departments?

8. What will be the method for returning used equipment and supplies to central service?

How frequently will routine return deliveries of used supplies and equipment from other departments be made to central service?

9. In view of the methods and frequency of distribution and return, what is the total estimated inventory of each type of supply and equipment which will be necessary to service the various hospital departments?

10. Is the division of central service into work areas or rooms to be entirely according to function (such as, receiving, disassembly and cleaning, assembly and wrapping, sterilization, storage and issue)?

Or, is there to be some division into work areas or rooms according to type of supply or equipment (such as glove processing room, solution preparation room)?

11. What will be the procedures for receiving and collecting and disassembling supplies and equipment as they are returned to central service?

What provisions should be made to carry out receiving, collecting and disassembling of supplies and equipment as planned?

12. What will be the procedures for cleaning each of the various types of supplies and equipment to be processed in central service?

How many work stations for cleaning are needed in order

to provide for adequate division of work and carrying out cleaning procedures as planned?

What facilities (sinks, counters, cabinets, mechanical washers) are to be provided in each of the work stations for cleaning?

13. What special facilities or equipment in addition to cleaning facilities are to be provided for preparing supplies and equipment for assembly and wrapping (glove tester, glove powderer, needle sharpener)?

14. What will be the procedure for inspecting, assembling and wrapping *each* type of supply and equipment (treatment sets, needles, syringes, surgical and obstetrical packs)?

How many work stations for inspecting, assembling and wrapping are needed in order to provide for adequate division of work and carrying out procedures as planned?

What facilities (counters, tables, lights) are to be provided in each of these work stations?

15. What practices and procedures are to be followed for flask washing, water distillation, and solution preparation?

What facilities (washers, still, sinks, work counters, cabinets) are necessary to carry out the preparation of solutions as planned?

16. What are the types, numbers and sizes of sterilizers necessary for processing the kinds and quantities of supplies and equipment which are to be handled by the central service (autoclaves, dry heat sterilizers, ethylene oxide sterilizers)?

What is the number of autoclave loading cars for which storage space must be provided?

17. What is to be the practice in regard to storing supplies and equipment processed in the central service?

Will the bulk of the supplies be kept in central service with a minimal supply in other departments?

Or, will a minimal reserve be kept in central service with a fairly large stock in other departments?

Or, will some other practice be followed?

What is the estimated quantity of supplies for which storage must be provided within the central service?

18. Will a separate room be required for the storage of large equipment or apparatus (oxygen tent, suction equipment, respirators, humidifiers)?

What facilities are to be provided for the cleaning of large equipment or apparatus?

What facilities are to be provided for the inspection and repair of large equipment or apparatus?

19. To what extent is storage of bulk or raw supplies to be centralized in one storage area or decentralized so that materials are stored in the area where they are used (*e.g.* linen in pack makeup area, new needles in needle assembly area, new gloves in glove preparation area, bulk textiles in packaging area)?

20. In what areas or at what work stations will electrical outlets, special lights, compressed air, vacuum, or other special facilities be needed?

21. Where are telephones, paging speakers, or other communication facilities to be located within the central service?

22. What record and inventory system is to be used?

What is the estimated volume of reference materials (catalogs, files and other resource materials) which will be needed in operating the central service?

What facilities will be required in order to maintain the record and inventory system and a reference file?

23. What office facilities are to be provided for the supervisor of central service?

24. What is the anticipated number of personnel who may be working in central service at one time?

What personnel facilities (toilets, lockers) are to be provided for central service personnel?

25. What methods and procedures are to be observed in the routine cleaning of the central service?

Who will be responsible for this cleaning?

What will be the procedures for the collection and disposal of all types of waste (broken glass, surgical wastes, waste paper)?

What will be the procedure for collecting and sending soiled linen to the laundry?

What facilities are needed to carry out the housekeeping functions (cleaning, laundry collection, waste disposal) as planned?

26. What provisions should be made for student education programs or for training programs for personnel?

RECOVERY ROOM

Checklist

The capacity of a recovery room will have been determined early in the programming when decisions were made as to the type and extent of medical services to be provided.

1. Will men, women and children be cared for in the same room or will separate facilities be provided for men, women and children?

2. What will be the general policy regarding the length of patients' stay in the recovery room?

3. Will regular hospital beds be used in the recovery room or will special recovery beds or carts be used?

4. How will patients be transported to the recovery room—on an operating or delivery table, a stretcher, a recovery cart or bed, or regular hospital bed?

Who will be responsible for the transport of patients to the recovery room?

5. How will patients be transported from the recovery room to the nursing unit—on stretcher, recovery bed, or regular hospital bed?

Who will be responsible for transporting patients from the recovery room to the nursing unit?

6. What provisions for oxygen and suction are to be made within the recovery room?

7. What provisions for the use of x-ray equipment are to be made within the recovery room?

8. What facilities (cabinet, shelf or table) are to be provided at each bed for placement of equipment needed in patient care?

9. Are sphygmomanometers to be wall hung?

10. How many electrical outlets are to be provided at each bed and where should these be located?

11. What provision should be made for screening patients when necessary?

12. What provisions are to be made for summoning physicians, nurses or other personnel required for emergencies?

13. What communication facilities (telephones, call system) are to be located within the recovery room?

14. What provisions should be made for the storage of blood, thermolabile drugs and biologicals within the recovery room?

What is the estimated quantity of these for which storage must be provided?

15. What is the estimated quantity of other drugs for which storage must be provided within the recovery room?

What facilities are needed for the storage and preparation of medications?

16. What is the estimated quantity of clean supplies and small equipment (bandage, tape, tissues, drainage and suction bottles) for which storage must be provided in the recovery room? (Itemize.)

What is the estimated quantity of sterile supplies and equipment (needles, gloves, syringes, treatment sets) for which storage must be provided in the recovery room? (Itemize.)

What is the approximate number of flasks of parenteral solutions for which storage must be provided in the recovery room?

What is the approximate number of flasks of other treatment solutions for which storage must be provided in the recovery room?

What facilities are to be provided for the storage of clean and sterile supplies and equipment and solutions?

17. What is the estimated quantity of clean linen, blankets and pillows for which storage is to be provided in the recovery room?

What will be the procedure for collecting and sending soiled linen, pillows and blankets to the laundry?

What facilities are needed for linen storage and the handling of soiled linen, blankets and pillows as planned?

18. What is the estimated quantity of large equipment or apparatus (bed rails, linen hampers, shock blocks, bed elevators, I.V. standards, oxygen tents) for which storage space must be provided in the recovery room? (Itemize.)

19. Will an ice supply be needed for tents, ice collars used in the recovery room?

20. What facilities are to be provided for emptying and cleaning emesis basins, urinals, bedpans and drainage bottles?

21. What used supplies and equipment will be cleaned and sterilized within the recovery room?

What used supplies and equipment will be collected and sent to central service or some other area for cleaning and processing?

What facilities should be provided for the collection and/or

the cleaning and sterilizing of used supplies and equipment?

22. What will be the procedure for cleaning a patient care unit after a patient has been returned to a nursing unit? Who will be responsible for this cleaning?

What will be the procedures for the routine cleaning of the recovery room? Who will be responsible for this cleaning?

What is the estimated quantity of housekeeping supplies and equipment for which storage must be provided in the recovery room? (Itemize.)

What will be the procedure for the collection and disposal of wastes (broken glass, paper, surgical wastes) from the recovery room?

What facilities are needed to carry out each of the housekeeping functions as planned?

23. What provision should be made for clinical and administrative record procedures?

What charting area(s) are to be provided for doctors and nurses within the recovery room?

What is the maximum number of persons for whom space should be provided in each charting area?

What is the estimated quantity of administrative and clerical supplies and equipment that must be kept in the recovery room? (Itemize.)

EMERGENCY DEPARTMENT

Determination of Emergency Services

1. What is the approximate daily number of emergency patients which may be anticipated?

2. Will there be a separate emergency service or will emergency service facilities be combined with the outpatient department or with admitting?

3. How many treatment rooms and examination rooms are to be provided for emergency service?

Checklist

The number of emergency examination and treatment rooms will have been determined early in the programming when decisions were made as to the type and extent of medical services to be provided.

1. What provision should be made for x-ray services for emergency patients?

2. What provisions should be made for laboratory services for emergency patients?

3. What special provisions should be made for the care of emergency patients with fractures?

In what rooms should these provisions be made?

4. Should special provisions be made for minor emergency surgery?

In what rooms should such provision be made?

5. Where should preoperative scrub facilities be located?

6. Will there be any use of explosive anesthetic agents in the emergency department?

What provisions are to be made to avoid anesthetic explosions and shock hazards?

7. What provisions for oxygen and suction are to be made in the emergency department?

In what rooms should these provisions be made?

8. Will treatment and examination tables be used in the emergency department or will special carts, which may serve for both examination and the transport of patients, be used?

9. What will be the procedure for admitting emergency patients?

Will patients on ambulance carts be transferred to examination and treatment tables in a special transfer area or in the examination and treatment rooms?

10. What provisions should be made for stretcher and wheelchair storage?

11. What is the maximum number of persons (patients, relatives and friends) for whom waiting space should be provided?

12. What public facilities should be provided for relatives, friends and news reporters (telephones, toilets, water fountains)?

13. What provisions are to be made for caring for patients held for observation or recovery?

14. What provision should be made for serving nourishment or meals to patients held for observation?

15. What toilet and dressing room facilities are to be provided for patients?

16. What provisions should be made for emptying and cleaning emesis basins, urinals, and bedpans?

17. What is the estimated quantity of drugs for which storage must be provided in the emergency department?

What facilities should be provided for the storage of thermolabile drugs and biologicals, the storage of other drugs, and the preparation of medications?

18. What provisions should be made for sterile water in the emergency department—flask system or water sterilizers?

If the flask system is to be used, what is the estimated number of flasks for which storage must be provided?

What is the approximate number of flasks of parenteral solutions for which storage must be provided in the emergency department?

What storage facilities are needed for solutions and where should they be located?

19. What practices and procedures are to be observed in the cleaning, sterilizing and storage of surgical instruments?

What facilities will be needed for the cleaning, sterilizing and storage of surgical instruments?

20. What cleaning, wrapping and sterilizing of other supply or equipment items (gloves, sutures, treatment rays) will be carried out in the emergency department?

What facilities are necessary to carry out this cleaning, wrapping and sterilizing of other supply or equipment items and where should these facilities be located?

21. What is the estimated quantity of clean medical supplies and small equipment (bandage, tape, plaster, utensils), for which storage must be provided in the emergency department? (Itemize.)

What storage facilities are needed for these clean medical supplies and small equipment and where should they be located?

22. What provision should be made for the storage of large equipment or apparatus (linen hampers, carts, solution standards, resuscitators, cast dryers) used in the emergency department? (Itemize.)

23. What procedures will be followed for the cleaning of an examination, treatment or minor surgery room after each use?

Who will be responsible for this cleaning?

What practices will be observed in the routine daily cleaning of the emergency department? Who will be responsible for this cleaning?

What will be the procedures for the collection and disposal of: (a) waste paper; (b) surgical waste; (c) broken glass, and (d) liquid waste from the emergency department?

What is the estimated quantity of housekeeping supplies and equipment for which storage must be provided in the emergency department?

What facilities are required to carry out each of the housekeeping functions in the emergency department as planned?

24. What will be the procedure for storage and distribution of linen in the emergency department?

What is the estimated quantity of clean blankets and pillows that must be stored in the emergency department?

What will be the procedure for collecting and sending soiled linen, blankets and pillows to the laundry?

What facilities are needed in the emergency department for handling clean and soiled linen, blankets and pillows?

25. What facilities should be provided for administrative and clinical record procedures?

What charting or dictating areas are to be provided in the emergency area?

What is the maximum number of persons for whom space is to be provided in each charting and dictating area?

What is the estimated quantity of administrative and clerical supplies and equipment that must be kept in the emergency department? (Itemize.)

What facilities must be provided for the storage and use of such supplies and equipment?

26. How many hours daily and how many days weekly will the emergency room be regularly staffed?

27. Where are telephones, paging speakers, or other communication facilities to be provided within the emergency department?

What communication facilities should be provided at the emergency entrance to summon personnel at times when the emergency department is not staffed?

28. What is the anticipated maximum number of staff (doctors, nurses) who may be working in the emergency department at one time?

What personnel facilities (toilets, lockers), are to be provided for staff in the emergency department?

29. What offices are to be provided for the staff (doctors, nurses) of the emergency department?

The design and appearance of Grossmont District Hospital, La Mesa, Calif., create an atmosphere of cordiality and friendliness throughout the hospital.

Modern Hospital of the Year for 1957: Grossmont Hospital, La Mesa, Calif.

THE Grossmont District Hospital, La Mesa, Calif., has been selected as the "Modern Hospital of the Year" for 1957. The selection was made by a committee of architectural and hospital authorities, following study of the projects presented in the "Modern Hospital of the Month" series during the year.

Grossmont Hospital was designed by Pereira and Luckman, Los Angeles architects, and it includes several design innovations.

"Use of a light curtain wall on the exterior was important in keeping total weight of the structure at a minimum," said James S. Moore of the architectural firm. "This is a definite advantage in areas such as Southern California, where earthquakes must be considered."

Arrangement of facilities and selection of structural materials also comprehended the need for flexibility to provide for future expansion, the architects reported. "Medical science is progressing so rapidly that solid walls should not restrict or hamper the adaptability of these technics to existing facilities or future planning," Mr. Moore said. "Therefore, clinical and surgical facilities were enclosed in a windowless, air-conditioned box. All are grouped closely together to consolidate expensive plumbing and air-conditioning runs. The roof over this area is supported by trusses that span the entire width of the area, thereby eliminating columns which would hamper future alterations."

The hospital was planned for an initial capacity of 105 beds; eventually, the capacity will be expanded by an additional 150 beds. Total project cost, including equipment, was $1,634,323. The hospital as built includes 63,187 square feet, or 602 square feet per bed. The construction cost per square foot was $25.86.

An outstanding feature of the hospital, according to Louis M. Peelyon, administrator, is the distinctive lobby. "The design has attracted frequent comments from patients and visitors who say it gives the feeling of a resort hotel rather than a hospital," Mr. Peelyon said. "This design has encouraged the operation of a hostess service by the women's auxiliary. An auxiliary member greets patients and families at the door as a cordial hostess, rather than leaving them to find their way to an information desk for directions. The atmosphere of the entire hospital is one of cordiality and friendliness, and this atmosphere, created by the design and the appearance of the structure, translates itself into the attitude of staff members and auxiliary members and, ultimately, the feeling of patients toward the hospital."

Members of the consultant committee making the selection for "Modern Hospital of the Year" were: Carl A. Erikson of Schmidt, Garden & Erikson, architects, Chicago; August Hoenack, chief, Architectural and Engineering Branch, Division of Hospital and Medical Facilities, U.S. Public Health Service, Washington, D.C., and Dr. Jack Masur, assistant surgeon general of the Public Health Service and director of the Clinical Center at Bethesda, Md.

They Have Such Awful Manners in Hospitals

A patient who appreciates the good things about hospitals still wants to know why employes can't take time to be friendly and courteous; why nobody thinks a patient's time is valuable, too, and why more thought isn't given to providing a few amenities to make hospitalization tolerable

A PATIENT, after all, has something to do with a hospital. The patient was there before the hospital was. These observations represent what one patient recalls after five days in a very fine hospital—five days in which he was jabbed into and at, starved, x-rayed, repeatedly drained out, and pumped up. Finally, he underwent a relatively minor operation; then, in a short time, he popped out of bed and drove himself back out to the country. He is heartily in favor of hospitals and expects they are here to stay.

This is being written in a spirit of critical humility. I am overflowing with gratitude to my doctors, to my hospital, to Divine Providence. At the same time I don't think any hospital or any doctor will be damaged by a bit of honest criticism.

1. Hospitals have forgotten all about common courtesy. Even present-day railroads, bad as they are, exhibit better manners toward their patrons than hospitals do toward their patients. I say present-day, because railroads of a few years ago were the prize example of how not to treat the public. Their code was "the public be damned," and they didn't change it until public relations advice made itself effective at high levels, but by then the damage had been done. They had a monopoly, or thought they did, and misbehaved accordingly. The railroads paid a heavy price for this attitude when airlines came along with credit cards, smiling hostesses, and rare steaks.

Hospitals now have a type of monopoly, too, but who knows for how long?

It is not a distortion of the facts to say that federal control of hospitals will be avoided just so long as the public is satisfied. And the little aspects of hospital mismanagement are what breed dissatisfaction. The big, important, technical and scientific advances in medical care and hospital administration generally are so far removed from the average patient that they evoke no feeling whatever, either of satisfaction or dissatisfaction.

The hospital that I was in is exceptionally well run, medically and administratively. The issues raised here certainly apply with greater validity to thousands of other hospitals that do not meet this hospital's standards.

Back to the amenities—or their absence.

I happened to be in a four-bed room, but my criticisms apply equally to a two-bed room, and, in most instances, to a private room.

It is human nature to want to know at least the names of the people you deal with. Even railroad etiquette has progressed to the point where you shake hands with people in the bar car. And what is the first thing you do at a conference? Why, of course, you are introduced all around.

But what happens in a hospital, where you are intimately associated with a number of people for days or weeks? Generally, nothing. You meet as strangers and you part as strangers.

The nurse or aide who first takes you in tow knows your name, but you don't know hers. Yet you are in her hands, a stranger in a world that is all new and often frightening. Does she introduce herself, explain that she will be on duty over a certain number of hours? Oh, no! With one exception, mine didn't. Why couldn't she have said, "I'm Sally Peterson, and you will be seeing me when you need me!"

Another thing about names. You come into a four-bed room. There are three other patients, in various states. When you enter, they all look up. Some smile, some grunt, some stare. That would seem to be the proper moment for the nurse or the aide to say, "Mr. New, this is Mr. Smith, Mr. Jones, Mr. Savola." Such around-the-room introductions may be standard procedure in some hospitals, but they certainly aren't in the hospital that had me for five days.

The desire to possess is a strong factor in subconscious human nature. You can't be any place for long—office, factory, hotel room, hospital room—without developing a proprietary interest in the location. It is a part of you, and you feel you should have some control over it. Yet miscellaneous people from the hospital staff burst into your hospital room at any hour and, in a sort of silent trance, go about performing their various and separate chores. You don't know their names and have trouble puzzling out their missions, and they don't seem to care. Automatically, you resent them.

This is not a workhouse, you tell yourself, and you are not here under a seven-day sentence. You have all the rights of any other citizen. Di-

rectly or indirectly you are paying all these people for every minute they are in the room. There is nothing basically wrong with these people, you have to remind yourself, but there is with their training in manners!

In my case there was one charming exception. A little, snub-nosed nurse's aide walked up to my bed and refreshingly said: "You don't know my name, do you? I'm Chris, that's for Christine." She exercised as much human psychology as anyone I encountered in the hospital.

Now don't say that hospital staffs are too busy to act like ordinary, sociable people, or that hospitals are so hard up they can't waste expensive time on meaningless frills! I'm talking about things that would cost no money at all, and almost no time. I'm talking about a change in attitude, not a change in the balance sheet.

2. Doctors and nurses are always busy, but patients have all the time in the world. The morning after my admission I was taken to the x-ray room for pictures, which turned out to be inconclusive. Another set of x-rays was ordered, a wise and proper decision that was to save me the expense and anguish of a major abdominal operation. But were the second pictures taken later that same day (a Friday) so the operation could be performed on Saturday as scheduled? Of course not. They were taken the next day.

This meant the minor operation that was necessary was put off until Monday. No one was particularly concerned at the time, least of all this patient. But what were the consequences? My Blue Cross plan was taxed $40 or $50 that could have been avoided. Because my operation was delayed two days, someone else who wanted to enter the hospital on Sunday perforce was told to come in on Tuesday. I missed two more days of work; I lost nothing on this, but my employer certainly did.

To sum up this point, there might be a reexamination of the thesis that doctors and hospital staffs are so busy the world has to revolve in their orbit. There must be other busy people, people as busy as doctors, whose time is wasted the way mine was.

3. Some patients can read. Not being too familiar with the particular statistics, I don't know how many patients, or what percentage, are so ill or uncomfortable that they don't want to read, or how many patients never learned to read.

I do know that outside the hospitals almost everyone does some reading every day, varying from a few minutes to several hours. People in general even are encouraged to read. Because a person enters a hospital it shouldn't be assumed that he is prepared to break off the life-long habit of reading.

In my hospital—and I know that is the arrangement in many others—someone from the outside makes the rounds with newspapers and magazines. Daily an old gentleman passed our door, but not at the same hour, and if you missed his barely audible "newspapers, magazines?" you were out of luck for the day, or at least out of reading.

Why can't the hospital take over this concession? The orderlies could check with patients on arrival to see if they wanted a morning or evening paper delivered regularly as long as they were in the hospital, or this information could be picked up on admission. The hospital also could easily work up a list of the more popular magazines and have patients check off their preferences, the way my hospital circulates a menu a day

IF YOU WANT TO KNOW WHAT PEOPLE REALLY THINK OF THE HOSPITAL,

A RECENT survey to determine the desires of pocket book readers seems to prove the adage, "What people say may not necessarily be what they really mean." When potential buyers were asked, face to face, what types of pocket books they would like to see published, their responses emphasized Shakespeare, philosophy, and the social sciences.

After questioning, the same readers were asked to mark, in private, the title of the one pocket book they would like to buy from a list of 100 selections. This anonymous choice was almost unanimous — "Murder in the Burlesque Theatre."

The hospital administrator might do well to heed this lesson. That is to say, he might better rely less on a patient's direct answers, and more on what a former patient says in private, after he has returned home from a hospital stay. Where can this "anonymous" information be obtained? From the physician who continues the care of the patient after discharge.

The patient judges medical care by what he sees, hears, tastes and, most of all, feels. All the scientific miracles in the world have no public relations impact when they happen behind the scenes. The doctor who works with his hospital administrator in diagnosing an existing public relations illness as soon as possible can boost his own public relations rating, as well as that of the hospital that serves his patients, by making the quality of medical care apparent rather than apathetic.

The following is an example of what a hospital director would be the first to correct, if it were brought to his attention.

A physician-acquaintance went to a large teaching hospital for a series of laboratory tests. A definite appointment had been made a week in advance, and, in addition, he carried with him, on the attending physician's prescription blank, an outline of the procedures to be performed and the rooms where he was to report. His first hospital meeting as a patient, rather than a doctor, was with the matron at the information desk.

"Where is the elevator, please?"

"What for?"

"Uh-h, I'm looking for the BMR room."

"Why?"

"I beg your pardon?"

"What do you need a BMR for?"

"Is it necessary that I tell *you* the reason for my being tested?"

"You'll have to tell me before I'll let you go upstairs and. . . ."

At this point the receptionist's telephone rang and the doctor took the opportunity to look for the elevator himself.

On entering the BMR testing room, the doctor was told he was five minutes too early and would have to wait. Then, after waiting 40 minutes while the technicians rehashed their previous evening's escapades, the test was finally started.

Next came the clinical blood tests. Arriving at the laboratory,

Dr. Pinckney is assistant editor of the Journal of the American Medical Association.

in advance to allow patients a choice. Here also would be a regular profit for someone – and another welcome service for patients. Don't argue that there isn't time for this sort of thing. The work could easily be fitted into slack hours, if anybody cared about getting it done.

4. What's this pill for? On prescribing medicine, most doctors tell the patient what the medicine is and what it is supposed to do. So why do hospitals make medicines so mysterious? My surgeon had prescribed an antibiotic, a standard preoperative procedure. Yet it was some time before I got that information out of a nurse. I knew what the pills were for, and she did, too, or should have. So why the mystery? Why not, with the first pills, have her say: "These pills are antibiotics, and your doctor wants you to have them to help fight possible infection after your operation."

As patients, we naturally are very interested in ourselves or we wouldn't be in the hospital. Naturally, too, any medicine is prescribed solely to help us in one way or another. We welcome any bit of information on what is being done to us. Being let in on these top secrets wouldn't make bitter pills any sweeter, but they might slide down easier.

5. Some patients can see and hear. I have made a few inquiries, and I have found no responsible medical person who would say that there is a medical hazard in television. I would think, then, that for the ambulatory, not-too-sick patient television would be of some therapeutic value–for escape at least. But in my hospital television viewing was discouraged, although probably not by design.

A television set can be rented for $10 a week, with a $10 minimum charge, from a commercial television shop. Doubtless the dealer has to get that much to make it profitable to bring the set in and out of the hospital. But $10 is a substantial amount of money when you may want the set for only a few hours and when you are juggling other financial obligations to make room for the hospital bill you know is coming up. So you don't rent a set.

I inquired three times if there were locations in the hospital where television could be viewed. No, there were not, or I had questioned the wrong people. Yet this hospital had what might be called a social room. Why not one or several sets there, with possibly a small fee for their use, or coin sets? With a relatively small investment the hospital itself could supply individual sets. Rental could be scaled down for a single day or evening, and still produce a profit. Many patients confined to bed would gladly pay a dollar or so to break the monotony of sleep–pills–read–pills–eat–pills. Even some railroad stations now have television sets, and it's a pretty crummy bar that doesn't have two.

6. Don't bore us with your family fights. One consolation of a hospital visit is the respite from disputes and arguments, business, professional or domestic, that most people experience every day of the week. So it is a rare patient, I would guess, who cares whether the head nurse is a witch or the chief of surgery is a demon. Nurses and orderlies: Please don't rehash who-said-what-and-when-and-why in a patient's room!

7. Patients want to help. You don't have to go deeply into psychology before you learn that the quickest and easiest way to forget your own problems, or to put them in their

(*Continued on Page* 129)

ASK DOCTORS TO REPORT PATIENTS' COMMENTS

EDWARD R. PINCKNEY, M.D.

the doctor took his place in the waiting line with other patients. When he finally was called, and produced the requisition form from his own doctor, he was asked, "Where is your receipt?"

"What receipt?"

With a look of annoyance usually reserved for the fourth-year medical student who has forgotten the location of the appendix, the technician answered: "You can't have any laboratory work done until you show me you've paid for it first."

"But. . . ."

"There are no buts!"

The doctor had many more experiences that day, but it is hoped these incidents will show why he did not come away with a favorable impression of that particular hospital.

Planned public relations means nothing in the face of poor communication between the patient and a representative of the hospital. But the most important finding was yet to come. When the doctor related his experiences to me, I asked, in all sincerity, "Did you tell this to the administrator?"

"Good Lord, no! I wouldn't want to say anything that might affect the quality of care I was getting, or the work still to be done," the doctor said.

This doctor's experience made me look a little further into the average hospital's public relations approach. And the results were quite consistent. It is not unusual for the patient never to find fault while *in* the hospital, thus the complacency in today's hospital public relations activities.

On discharge, the patient will profusely thank the nurses, the dietitians, and the aides for a "wonderful" stay. And then, once settled at home, he will tell about his recent hospital visit as if he had spent the last few days or weeks on Devil's Island.

To whom does the patient expound? Mostly to his family and friends, who nod understandingly but who would not want to complain to the hospital authorities themselves for fear that they too might someday have to "serve time." And, in addition, patients tell their complaints, both physical and hospital, to their personal physicians.

The hospital administrator should be able to rely on his medical and surgical staff members just as the pocket book publishers use their anonymous questionnaire. Not only can the administrator become aware of breakdowns in public relations as they *appear* to the public, but, of greater importance, he enlists the physician as an all-round member of the team. If the doctor were the immediate respondent for the patient's complaints, the hospital administrator could have a tremendous public relations staff without spending one extra cent for such surveys and services.

Just as readers of pocket books say one thing publicly and another privately, so it is with the hospital patient. To find out what is said "privately" is the true measure of a hospital's public relations.

University of Minnesota Studies Salaries of Its Graduates in Hospitals; Median Is $8500

MINNEAPOLIS. — Median salary for graduates of the University of Minnesota hospital administration course now working in hospitals is $8500, with median job tenure two years, a study has found.

The pilot study, based upon 191 graduates of the university's course during its first 10 years, 1946-56, was made by Edith W. Lentz, assistant professor and research director, and Robert G. Michaels, instructor and research assistant. The study and its publication were financed by funds from the W. K. Kellogg Foundation.

A religious orientation and spirit of service and the ability to enjoy human relations tasks influenced the degree of satisfaction administrators found in their jobs, the study reported.

A total of 147 graduates replying to the questionnaire are working in hospitals, as administrators, assistant administrators, administrative assistants, department heads, and others. Salaries of 38 of these graduates were not reported. In the nonhospital category, which included teaching and research, clinic managers, and other health fields, 44 graduates were tabulated; 22 salaries were unknown.

77 PER CENT IN HOSPITALS

Those working in hospitals totaled 77 per cent of the graduates; 35 per cent of these are now administrators of hospitals. A 1957 study of Columbia University's graduates in hospital administration found approximately 75 per cent of its graduates working in hospitals, with 40 per cent of these employed as administrators.

Highest salaries in the hospital field were received by administrators of 200-299 bed hospitals, whose pay ranged from $9000 to $20,000, the highest salary reported in the study. Administrators in this group also had the longest tenure, 5.5 years.

Of those graduates in nonhospital fields, median salary was $9120. Highest salary reported was $15,000, and lowest was $4800. Lowest salary in the hospital category was $3720, for an administrative assistant.

Administrators of hospitals with fewer than 100 beds had a salary range of $5400 to $11,000, with a median of $8200 and median job tenure, or length of stay in the position held at the time of the survey, 1.5 years.

In hospitals with 100-199 beds, the administrator's salary ranged from $5400 to $18,000, median salary being $9200. Median job tenure was 3.5 years. Assistant administrators in hospitals this size earned from $5200 to $9000, with a median salary of $6950, and median tenure of 0.5 years.

Assistant administrators in the 200-299 bed hospitals earned $6480 to $9600, with a median of $8200, and median tenure of 2.5 years.

Hospitals of more than 300 beds paid their administrators $10,000 to $13,000, with a median of $12,000. Median job tenure was 0.5 years. Assistant administrators in hospitals of this size earned $6000 to $11,000, the median being $8200. Median tenure was 1.75 years.

Administrative assistants reported a salary range of $3750 to $7100, with a median of $5400, and median tenure of one year. Department heads and other hospital employes who were graduated from the hospital administration course earned from $4000 to $7000, the median figure being $4800. Median job tenure was 1.5 years.

"It is exceedingly difficult to measure position change," the study reported. "For example, some hospital administrators may appear to be standing still, status-wise, insofar as they are in the hospital they started in, and are called by the same title. Under their administration, however, the hospital may have doubled in size and improved markedly in efficiency of service.

"One thing we can measure is the extent of 'hospital hopping.' This proves to be minor among Minnesota graduates. During the last 10 years the 'average graduate' has worked in two different hospitals. Many of the more recent graduates, of course, are still in their first position, while some of the men out longest have been in as many as four. If we select only the graduates from the first four classes, we found that they average 7.5 years in the field and have worked in 2.5 hospitals. They have been in their present positions an average of 3.5 years."

Comparison of salaries received by graduates of Columbia University's hospital administration program and those of the University of Minnesota's course reveals that, on the average, Columbia graduates earn more money per year. Accounting for the difference in salaries, the study pointed out that Columbia graduates have tended to settle in the New York area where hospitals tend to be larger and salaries higher. Both schools report a fairly steady rise in salary level for each year the graduate has been out of school, the Minnesota study of its graduates found.

"When it comes to the person who 'traveled farthest' in terms of career achievement," the study said, "the profession of hospital administration can boast that the longer a person has been in the field, the more satisfaction, salary and status he can expect to achieve.

"We found that graduates with the best academic standing in graduate school won the top administrative posts in university and other large hospitals, as well as positions of leadership in allied health fields and in scholarly pursuits. However, these were not the individuals who expressed feelings of greatest satisfaction in their work," the study said.

In general, the report stated, those working in hospitals are highly satisfied with their career choice, more so than those who have ventured into other areas. The most satisfied graduates were those who were administrators of 200-299 bed hospitals, especially those in church hospitals.

Neither Columbia nor the University of Minnesota is meeting the needs of smaller hospitals, the study asserted. The majority of graduates from Minnesota, like those from Columbia, are in the larger, nonprofit, nongovernmental, short-term general hospitals.

SHOWED HIGHER SATISFACTION

People over 33 years of age when they entered the graduate course showed high career satisfaction, as did those from rural areas whose fathers were farmers, the report stated, although the majority of high achievers were persons whose fathers were in managerial occupations and who were 28 to 33 years of age when they entered graduate school.

Although slim, present evidence seems to indicate that graduates who came from professional homes and considered themselves to be upper or upper middle class in origin were not as satisfied in positions of hospital administration as are their fellow administrators, the study noted.

"Better off," the report said, "are those whose fathers held managerial positions (perhaps not too distant in social status from the hospital administrator) and who saw themselves as middle class during their growing years."

The study found that a religious orientation, particularly growing up in a family atmosphere of reverence and the spirit of service, seemed to go along with finding hospital administration rewarding work.

"Most of all," the researchers said, "high satisfaction in this field seems related to the facility to find rewards in the liaison activities, or human relations tasks, which characterize the life of the administrator."

ABOUT PEOPLE

Administrators


Dr. H. M. Wortman

Dr. Herbert McC. Wortman, former executive vice president and director of Children's Hospital of Philadelphia, has been appointed administrator of Beekman-Downtown Hospital, New York. Before going to Children's Hospital in 1951, Dr. Wortman served as assistant director and as director of Mountainside Hospital, Montclair, N.J., for 14 years. A fellow of the American College of Hospital Administrators, Dr. Wortman has held many posts in hospital and medical organizations. He is a member of the advisory board of the Hospital Council of Philadelphia, a charter member of the Children's Hospitals Executive Council, and a past president of the New Jersey Hospital Association. He will succeed **Joseph Peters** as administrator of Beekman-Downtown Hospital. Mr. Peters, a graduate of Columbia University's hospital administration program, has been appointed staff consultant for the Hospital Council of Greater New York.

Dr. F. Lloyd Mussells, executive director of Philadelphia General Hospital, has been appointed director of Peter Bent Brigham Hospital, Boston, effective June 15. He will succeed **Dr. Norbert A. Wilhelm,** who retired last June after 25 years at the hospital. Dr. Mussells became associated with Philadelphia General Hospital in 1953 as medical director. He was appointed executive director in May 1954, after serving for several months as acting director. He received his medical degree from McGill University Faculty of Medicine and a master's degree in hospital administration from Columbia University. He is a member of the American College of Hospital Administrators.


Wendell H. Carlson

L. C. Vonder Heidt, administrator of West Suburban Hospital, Oak Park, Ill., for more than 30 years, has announced his retirement. Mr. Vonder Heidt is a charter fellow of the American College of Hospital Administrators and a life member of the American Hospital Association. He will be succeeded by **Wendell H. Carlson,** executive director of the Chicago Hospital Council and former administrator of Englewood Hospital, Chicago. Mr. Carlson is a fellow of the American College of Hospital Administrators.


Melvin H. Dunn

Melvin H. Dunn has been appointed director of Children's Mercy Hospital, Kansas City, Mo., effective June 1. Plans are under way to expand the hospital to a complete medical center for children under age 16. The name will become Mercy Medical Center for Children. Currently, Mr. Dunn is director of Church Charity Foundation of Long Island, Brooklyn, N.Y., a position he has held for more than seven years. The foundation includes St. John's Episcopal Hospital and a school of nursing, a home for the aged and blind, a Sisters' home, and a number of emergency and ambulatory clinics. Before going to the foundation, Mr. Dunn was associated with St. Luke's Hospital, Kansas City, Mo., for 18 years.

Dr. Eugene D. Rosenfeld, executive director of Long Island Jewish Hospital, New Hyde Park, N.Y., has resigned to become consultant for the Hadassah-Hebrew University Medical Center, now under construction in


Dr. E. D. Rosenfeld


Martin Saren

Israel. His office will be located at the Hadassah organization in New York City. **Martin Saren,** assistant director of Long Island Jewish Hospital, has been appointed acting administrator. Before going to the hospital in 1953, Mr. Saren was assistant director of Grasslands Hospital, Valhalla, N.Y.

Raymond DeTroyer has been appointed administrative assistant in charge of communications, purchasing and transportation for Long Island Jewish Hospital, New Hyde Park, N.Y. Previously, Mr. DeTroyer was purchasing director of Lenox Hill Hospital, New York.


Vernon D. Brammer

Vernon D. Brammer has been appointed administrator of the Kaiser Foundation Hospital, San Francisco. He previously was administrator of the Kaiser Foundation Hospital in Vallejo, Calif. Mr. Brammer joined the Kaiser organization in 1946, after serving two years with the U.S. Maritime Service during World War II.


William R. Sittler

William R. Sittler has been appointed administrator of Walther Memorial Hospital, Chicago, succeeding the late **William C. Gronert.** A graduate of Northwestern University's hospital administration program, Mr. Sittler previously was assistant administrator of Evangelical Hospital, Chicago. He served his administrative internship at Augustana Hospital, Chicago.

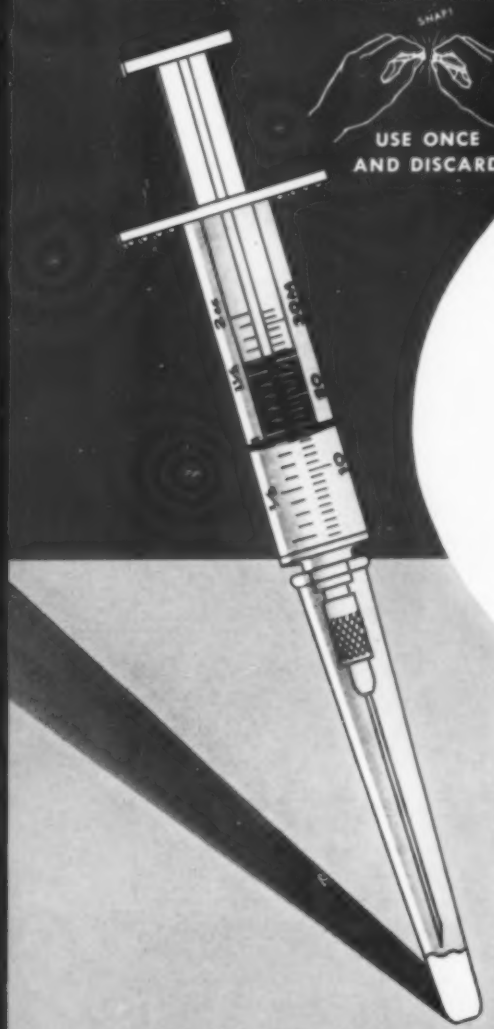
Dr. Linus A. Zink has been named to succeed **Dr. Frank B. Brewer** as assistant chief medical director for operations in the Veterans Administration, Washington, D.C. Dr. Brewer will retire this month after 41 years of federal service. Dr. Zink has been deputy assistant chief medical director for operations since 1953.

Nathan W. Helman, administrative director of Mount Sinai Hospital, Chicago, has been named director. He succeeds **Dr. Stephen Manheimer,** who resigned from the hospital in February 1957.

Thomas A. Larkin has been named administrator of Children's Hospital in Baltimore. Mr. Larkin, who received his master's degree in hospital administration from Columbia University, has been assistant administrator of Reading Hospital, Reading, Pa., for the last five years. He will be succeeded at Reading by **James B. Gronseth,** administrative assistant. Mr. Gronseth is a graduate of the hospital administration course at Northwestern University. (*Continued on Page* 164)

Admiral. SDS

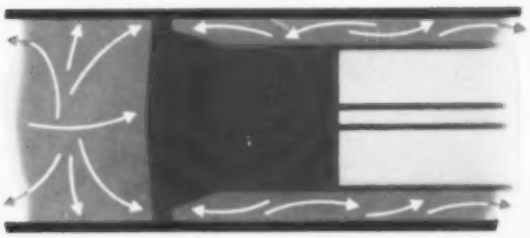
Sterile Disposable Syringe



Examine it . . . feature by feature

FEATURE: NO TRAPPED AIR

Single ring plunger design assures complete sterilization. Elimination of multiple plunger rings prevents the pockets of trapped air that may escape sterilization.



FEATURE: No "needle tattoo"

Admiral's exclusive cleaning process assures absolute needle cleanliness. Prove it with the "cloth test." Push an Admiral SDS needle through a clean, white cloth. Examine it under a microscope. No trace of dirt appears.

FEATURE: Cotton safeguards sterility

The cotton pellet in the needle guard protects against loss of sterility between nursing station and patient. Only cotton, the proven bacteria barrier, can assure absolute sterility.

FEATURE: No loss of medicaments

When depressed, plunger fits snugly against end of barrel, completely emptying the Admiral SDS.

Available in all types and sizes

Intramuscular, intravenous, subcutaneous, serology, tuberculin, insulin—in many gauges, needle lengths and calibrations.

WRITE FOR INFORMATIVE BOOKLET and price list

Admiral CORPORATION

HS/d HOSPITAL SERVICE DIVISION

P.O. Box 338, West Chicago, Illinois

Conducted by Robert F. Brown, M.D.

How Laboratory Service Can Be Improved

Laboratory errors that affect patient care can be reduced if the administrator will provide clerical help to prepare charts that show how the laboratory is performing and how mistakes can be corrected

ROBERT G. HOFFMANN

IS YOUR laboratory operating properly? This matter should be of concern to all hospital administrators, and the fact is that many laboratories are not operating as well as they should. Pathologists have recognized this problem and have been working on it for a number of years. Much, however, remains to be done.

The purpose of this paper is twofold: (1) to acquaint hospital administrators with this laboratory problem, and (2) to show them that they, as administrators, can contribute materially to improvement of the service in their own laboratories.

Before we go into the details, first let us consider some of the background on the problem.

RESULTS OF A SURVEY

About 10 years ago, the committee on laboratories of the Medical Society of the State of Pennsylvania conducted a survey to check on the accuracy of some common chemical measurements made in hospital laboratories. Standard solutions of known concentrations were sent to 59 laboratories in the state. A portion of the results of the survey are presented in Table 1, p. 104.

The table indicates for each substance the number of laboratories returning a test result, the per cent of the laboratories whose results were not satisfactory, and the per cent of laboratories whose results were in gross error. The proportion of laboratories that were unsatisfactory includes those in gross error. Satisfactory limits for each test were established by referees who conducted the study.

FIG. 1—DISTRIBUTION OF LABORATORIES BY ERROR REPORTED IN TESTING A STANDARD HEMOGLOBIN SPECIMEN

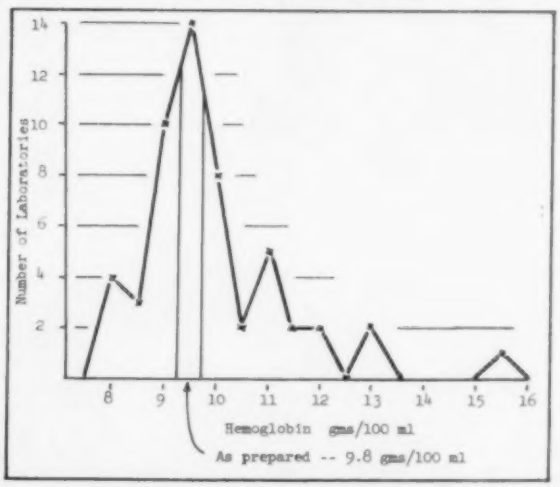


Fig. 1 presents a distribution of laboratories from the Pennsylvania survey by the hemoglobin value each reported for a standard specimen. This figure presents a picture of pure laboratory error because all laboratories were testing a specimen prepared at 9.8 Gms. Deviations from this mark are the laboratory error.

Only a glance at Table 1 is sufficient to see that the situation leaves much to be desired. Most satisfactorily performed was the sodium chloride test; in it about one-third of the laboratories reported unsatisfactory results. The worst was for albumin; in this test 80 per cent of the laboratories reported unsatisfactory results. Note particularly in the table the high percentage of unsatisfactory results for the hemoglobin tests. Sixty-seven per cent were unsatisfactory, and 22 per cent were in gross error. This is one of the commonest of all laboratory tests, and even small errors can affect the care of many patients. More will be said about the hemoglobin determinations later.

Figure 1 presents a distribution of laboratories from the Pennsylvania survey by the hemoglobin value each reported for a standard specimen. The specimen was prepared at 9.8 Gms./100 ml. The vertical band on

From 1953 until late last year Dr. Hoffmann served with the Commission on Professional and Hospital Activities, Ann Arbor, Mich., which developed a technic of making hospital and medical statistics more useful to doctors and hospital administrators. Since then he has been appointed statistician at the J. Hillis Miller Health Center and assistant research professor at the University of Florida's statistical laboratory at Gainesville. This article is an outgrowth of Dr. Hoffmann's work toward his Ph.D. in public health statistics.

stops bleeding
that ligatures can't curb

Oxycel

Absorbable Hemostatic

OXYCEL (oxidized cellulose, Parke-Davis) effects prompt hemostasis in capillary bleeding not amenable to control with clamp and ligature. Applied directly from container to bleeding surfaces, this absorbable hemostatic shortens operative procedures, and helps to prevent postoperative hemorrhage.

Sterilized, gauze-type, 3 inch x 3 inch eight-ply pads, and 4 inch x 12 inch eight-ply pads.

Sterilized, cotton-type, 2¼ inch x 1 inch x 1 inch portions.

Sterilized, four-ply, gauze-type strips, 3 inch x ½ inch; 18 inch x 2 inch; 36 inch x ½ inch; and 3 yard x 2 inch, pleated in accordion fashion.

Sterilized, four-ply, gauze-type discs, 3-inch and 7-inch diameters, conveniently folded in radially fluted form.

Supplied in individual glass containers.

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

Figure 1 indicates acceptable limits of accuracy established by the referees. On the left of the scale, there were four laboratories that reported values as low as 8 Gms. and, at the right of the scale, one laboratory reported 15.5 Gms. Figure 1 presents a picture of pure laboratory error because all 51 laboratories were testing a specimen that was prepared at 9.8 Gms. Deviations from the 9.8 Gms. mark are the laboratory error.

At this point the reader might say: "This is all well and good, but the data presented here are about 10 years old and things may have improved in the meantime." Some more recent surveys have been done and some improvement has been noted, but much remains to be done. For example, consider some recent hemoglobin data.

AVERAGES, BLOOD USAGE

Figure 2 presents a comparison of hemoglobin averages taken over a recent six-month period. Sixteen hospitals are mentioned in the article, with the hospital with the lowest average reporting 11.6 as compared to 14.1 Gms. for the hospital with the highest average, a range of 2.5 Gms. As 23,000 tests were included in the study (1056 and 876 tests for the lowest and highest hospitals respectively) the differences cannot reasonably be said to be due to chance variation. One might argue that this range of 2.5 Gms. is due to different kinds of patients being treated in the hospitals, but all are general hospitals with similar patient populations. The only reasonable conclusion is that many of the differences are due to laboratory differences.

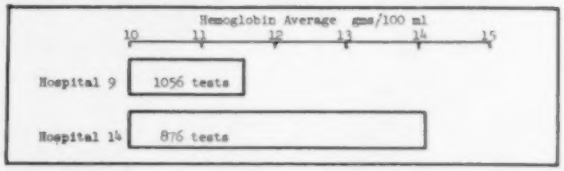
At this point, the reader might agree that there are some differences in laboratories, but the current information on hemoglobin tests does not indicate nearly as much variation as that seen in the study presented in Figure 1. "What difference," the reader might ask, "does an error of 1 Gm. of hemoglobin make in the use of the test result?" To answer this question some additional information is presented.

As evidence of the effect that a change of 1 Gm. of hemoglobin can have, consider the data from a single hospital[1] presented in Figure 3. The solid line indicates for each month the hemoglobin average for the hospital. For example, during January 1956, an average of 12.1 Gms. was reported, and in September 1956 an average of 13.1 Gms. was reported. The dashed line on Figure 3 indicates the number of pints of blood issued during the month. Note the sharp rise that occurred during the month of May in the hemoglobin tests. This laboratory

[1]Thanks are extended to this hospital for permission to use the information presented here.

FIG. 2—RANGE OF SIX MONTHS HEMOGLOBIN AVERAGES

Fig. 2 presents a comparison of hemoglobin averages taken over a six-month period.



restandardized its hemoglobin tests at this time, and the change is reflected in the monthly averages. The number of pints of blood issued per month also changed with the change in hemoglobin level. In fact, 87 fewer pints per month were used after restandardization as compared to the period before restandardization. On a yearly basis, this represents about a thousand pints of blood per year.

Here is graphic evidence that a change even as small as 1 Gm. of hemoglobin can affect the use of blood in the hospital and all of the treatments that such a change implies.

At this point the reader might say: "There is evidence that laboratory errors continue to exist and that patient care is affected by these errors, but what can I, as a hospital administrator, do about the situation? Is this not a pathologist's responsibility?"

The matter is primarily the responsibility of the pathologists, and they have been working on the problem for a number of years. Chemical solutions of known concentration are available from the American Society of Clinical Pathologists and other sources. A laboratory may check its procedures with the standards when such a check is indicated. There is, however, another method by which information can be obtained from the accuracy of the laboratory, and it is here that the administrator can help.

HOW ADMINISTRATOR CAN HELP

In a paper presented to pathologists in 1955, I proposed a method whereby information on laboratory performance can easily be obtained. The method proposed consists of averaging[2] and

[2]Averages are computed by taking the sum of the test values and dividing the sum by the number of tests used in the sum. For example, the average of the two hemoglobin tests of 13.0 and 14.2 Gms. is

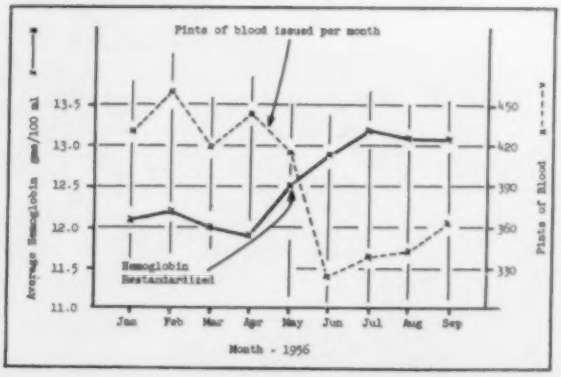
$$\frac{13.0 + 14.2}{2} = 13.6 \text{ Gms.}$$

TABLE 1—LABORATORIES REPORTING UNSATISFACTORY TESTS AND TESTS IN GROSS ERROR

Standard Substance Tested	*No. of Labs. Reporting*	*Per Cent of Labs. Unsatisfactory*	*Per Cent of Labs. in Gross Error*
Hemoglobin	51	67	22
Glucose	51	47	8
Sodium chloride	44	32	5
Total protein	47	62	15
Albumin	44	80	16

FIG. 3—HEMOGLOBIN AVERAGE AND PINTS OF BLOOD USED; BY MONTH, HOSPITAL X

Fig. 3: Solid line indicates hemoglobin average for the hospital for each month. Dashed line indicates number of pints of blood issued in month.



Now..."COLD" STERILIZATION WITH THE AMERICAN Cry-O-THERM

Climaxing more than eight years of intensive research and development by American Sterilizer, the *Cry*-O-Therm establishes wholly new standards for cold (gaseous) sterilization of instruments and wrapped or pre-packaged surgical and laboratory supplies. Simple to install, easy to operate, fast, safe and fully automatic, the *Cry*-O-Therm provides the first completely practical technique for hospital sterilization of heat- or moisture-sensitive items.

An Exclusive

new gaseous sterilizing agent known as Cry-OXCIDE *has been developed by Amsco. In convenient, disposable, aerosol containers, Cry*-OXCIDE *combines ethylene oxide and inert gases in a low-pressure, non-flammable, non-explosive mixture.*

Tested and approved by U. S. Bureau of Mines for hazardous locations.

Square 16" x 16" x 30" chamber has ample capacity for largest endoscopic instrument. Fully automatic with full-load cycles as fast as two hours.

Write for bulletin SC-310.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Offices in 14 Principal Cities

plotting the clinical results exactly as has been done in Figure 3 of this article. Since the paper was published in 1955, experience has shown, however, that the best results for hemoglobin tests are obtained when the averages are computed and plotted about once a week. The procedure, of course, should not be started until the laboratory has been checked for accuracy with chemical solutions of known concentration.

To my knowledge, this method of plotting averages of clinical specimens has not been widely accepted by pathologists. In two hospitals where the method has been used, useful information has been obtained. Errors have been corrected before they became large enough to affect patient care. This is the ideal use of such charts.

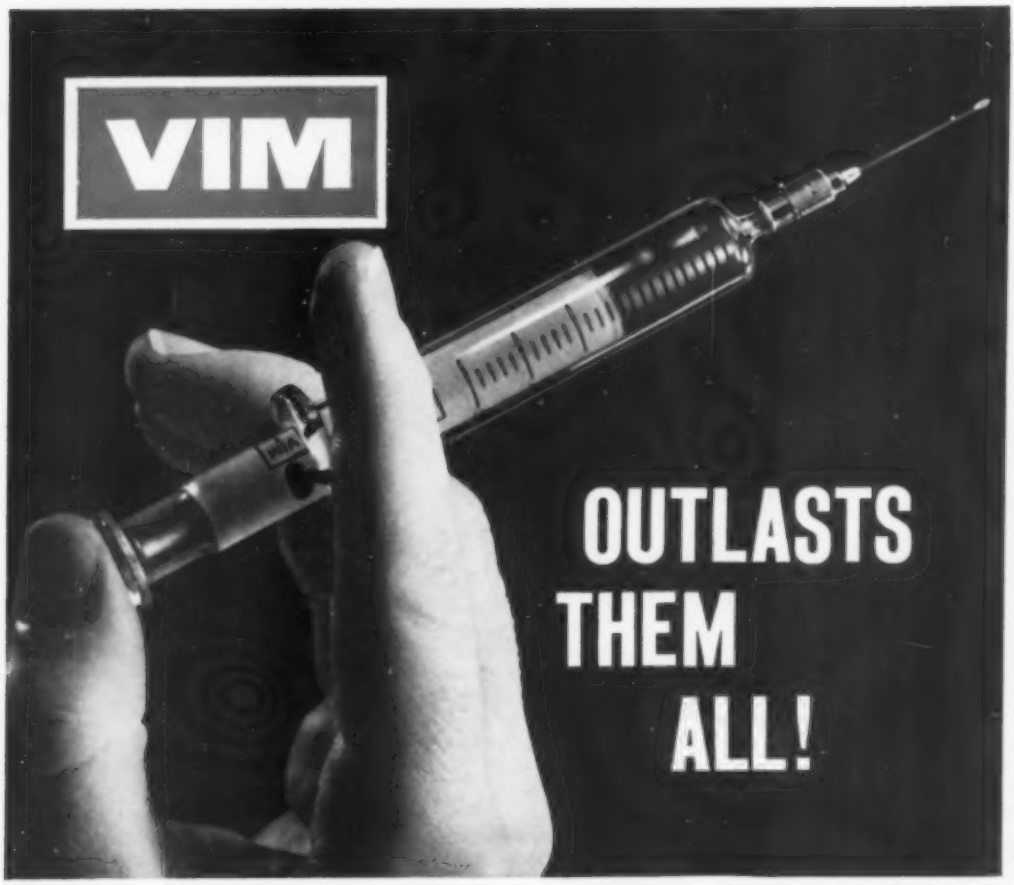
I have questioned several pathologists as to why they do not use this simple charting method as a means of obtaining information about their laboratories. They have replied that sufficient clerical help is not available to them. This is where the administrator can contribute. For a good bookkeeper or for some other person who knows how to add and average the values from the laboratory, this is a matter of only a few minutes of work per week. The administrator, by providing this kind of service to the laboratory, will be able to assure the pathologist that his laboratory is functioning properly. The information is also assurance to the administrative and medical staffs.

The care of large numbers of patients is materially influenced by the results reported from the laboratory. Is not a few minutes of clerical time each week well spent in providing information about how the laboratory is operating?

SUMMARY

Data have been presented in this article to substantiate the following statements:

1. Many laboratories are reporting erroneous results for some of the specimens being tested in the laboratory.
2. The error is large enough in some instances as to lead to inappropriate patient treatment on the part of the attending physician.
3. A simple method exists whereby information can easily be obtained that will aid in keeping these errors to a minimum.
4. The hospital administrator may assist in minimizing laboratory errors by supplying clerical help to prepare charts that depict the laboratory performance. The amount of clerical time required for keeping the charts proposed is counted only in minutes each week. The resulting information should be of interest and value to all members of the staffs of hospitals.



VIM LAMINEX* Needles actually last 2 to 4 times longer than ordinary hypodermic needles, without resharpening...without wear or breakage. Reason: VIM® Brand and only VIM uses LAMINEX Stainless Steel with the exclusive longitudinal molecular structure that makes possible "high-carbon" sharpness plus stainless steel flexibility and toughness!

VIM Clear Barrel Interchangeable Syringes continue to give perfect service long after ordinary ground-barrel syringes must be discarded because of erosion and "back-fire" leakage. Only VIM Clear Barrel Syringes are available with no-leak glass tips as well as Luer lock and Luer metal tips. And only VIM Clear Barrel Syringes are truly interchangeable... eliminate all matching of plungers and barrels.

Why not specify VIM ... and save?

CYANAMID
AMERICAN CYANAMID COMPANY
SURGICAL PRODUCTS DIVISION
DANBURY, CONNECTICUT

*Reg. U.S. Pat. Off.—S. & R. J. Everett Co., Ltd.

Producers of Davis & Geck Brand Sutures
and Vim Brand Hypodermic Syringes and Needles.
In Canada Distributed by North American Cyanamid Ltd., Montreal 16, P.Q.

Good Food Is Good Medicine for the Aged

Two nursing home operators report on ways to provide nutritious and satisfying meals to keep residents happy

As told to JOAN ROCK

WHEN some 30 to 50 old people, of widely varying ages, tastes, food habits and family backgrounds are gathered in a nursing home, with the prospect of eating many meals there, they pose quite a problem for the conscientious nursing home administrator. It is not easy to provide the residents with adequate, nutritious meals and keep them all happy, but it can be done. The operators of two nursing homes, one metropolitan and one suburban, who have learned the secret of creating mealtime harmony, explained their philosophy to a reporter and offered ideas that should prove helpful to administrators and dietitians of all institutions that serve aged patients.

J. Marvin Levinson, resident manager of the Mark Howard Home, Chicago (104 beds), and Ruth Cox Lucas, owner of Rest Home for Aged and Infirm, Elgin, Ill., (16 beds), serve quite different clienteles, but they agree that every nursing home has a moral obligation to see that the diet is nutritionally adequate for each individual within the group and, also, to protect and preserve the utmost in human dignity for each patient.

"When the food administrator of an institution fails to consider the original home habits and customs prevailing among his several patients and to make proper provisions for these in his meal planning and cooking," Mr. Levinson asserts, "the patients are not happy."

Says Mrs. Lucas: "The patient away from home, deprived of familiar companionship at mealtimes, familiar ways of cooking and serving food—even familiar or favorite foods—and who is now confronted with permanent or temporary infirmities, who is less active, often nonambulatory—that patient's reactions to food are of utmost importance. Meals may be both his recreation and one of his therapies; may be both a means of rehabilitation and a 'tool' by which group orientation and a satisfactory pattern of living are established."

They agree, too, that as many as 75 per cent of the patients entering their new environment have malnutrition symptoms, with vitamin deficiencies and overweight or underweight found oftenest. Additional dietary problems may include cardiac deficiencies, diabetes, gall bladder symptoms, postsurgical diet requirements, and so on. Added to this expanding picture of diet problems are the common difficulties of the aged patient such as dentures and inability to feed himself, chew well, and handle a knife, fork or cup. In addition the group must be resolved into feeding units, such as bed patients who are fed by a nurse or attendant; bed or chair patients with tray meals; patients who may enjoy eating together at a dining room table, and, of course, the staff units.

Mr. Levinson's nursing home is in metropolitan Chicago; no food is grown or raised. His operation is entirely financed from fees. Some needy patients are admitted without charge. These are, of course, special cases and are indicative of community responsiveness on the part of the home. His group is made up of Jewish, Catholic and Protestant men and women, most of them chronically ill.

Storage space is unlimited and freezer storage space is more than adequate for good buying. Meat freezer storage alone accommodates 2500 pounds. The cooking is done by a former chef who now, owing to age, fits well into the organization.

Mr. Levinson's first general menu objective is a high protein-low carbohydrate diet for all. Too many of the patients have been living on "snack meals"; too much coffee or tea, not enough milk; not nearly enough vegetables, and too many between-meals tidbits, he believes. The regime best liked by the group is a substantial early breakfast, a light lunch, and the big meal at night.

Meats are roasted or baked. They are bought cut to order, lean-trimmed, ready to cook, boneless. There is a minimum of waste by this practice and foolproof portion control. The home depends upon certain basic types of meat such as beef round, sirloin butts, stewing meat, veal rib eyes, briskets, turkey and chicken. Variety is ensured with boned fish (pike, rosefish, perch) and certain allowed accessory meats such as liver and tongue. No pork is served.

Staple fresh fruits and vegetables are served in abundance, and seasonal items when they are plentiful and economical. "We are proud of our homemade soups and desserts, and we have baked to order and delivered the 'egg bread,' or Chaleh, all our people love," Mr. Levinson says.

Encouraging the aged person to eat well is important. Certain forms of physical illness often can be overcome by happiness in eating. Lack of appetite or disinterest in eating may be the result of not being able to taste the flavors of foods fully. To encourage food flavor appreciation and to get food eaten, monosodium glutamate is used, particularly in soups and in stews and similar dishes. "We do not want the problem of leftovers, so meals are planned and cooked accordingly," comments Mr. Levinson.

(*Continued on Page* 110)

Brighten meals... lighten work... and cut clatter

with Roylies and Roylprint

TRAY MATS

STOCK AND CUSTOM DESIGN PRINTED PAPER PLACE MATS

One way to help keep patients happy is to serve meals on cheerful Roylies and Roylprints. They add so much color and gaiety to the drab, gray tray . . . and mealtime is a high spot in a patient's day. What's more—Roylies and Roylprints give you an extra measure of cleanliness and sanitation—utensils never touch the bare tray. Cleaning chores are easier too—you use Roylies and Roylprints once—then they're tossed away. And no more jolting noises—Roylies and Roylprints deaden harsh sounds. Choose from a wide variety of lively stock designs—or we'll print a special design for you with your name, and any color, artwork or motif you desire to fit in with your decor. (And the cost is surprisingly low!) Mail the coupon for samples.

Royal Lace Paper Works, Brooklyn 1, N. Y. *(Division of Eastern Corporation)*

Royal Lace Paper Works, Dept. MH-3
99 Gold Street, Brooklyn 1, N.Y.

Please send information on Roylprints and Roylies Place Mats—at no obligation to us.

Name_____

Address_____

City_____ Zone_____ State_____

(*Continued From Page* 108)

"These people, as a group, are dessert lovers; they are also nibblers between meals, and the nibbling habit is not easily broken when families and friends are generous with gifts. Nibbling is sometimes more than a habit really, it may be a tradition and we prefer to 'work around' it rather than forbid it, except when we are carrying out doctors' orders. We try to limit candy, and encourage fruit, for example. If the gift has been a pastry, we 'forget' to serve dessert. To forestall hunger pangs at the wrong hours, milk, as well as other beverages, is served to anyone at any time, day or night, on request," he says.

Management in the Mark Howard Home is relieved of detailed menu planning. With his long experience, the chef is fully capable of preparing excellent food and well balanced meals on his own initiative. In fact, one of his invaluable contributions is his point of view about food for the elderly because of his own age and changing taste and preferences.

Breakfasts exceed the standard for a good breakfast with fruit, cereal, eggs or other hot dish, bread, milk and a hot beverage, jelly or jam on the menu. Soup is served at noon and at night; each noon meal is supplemented by cottage cheese and fruit, in addition to the entree and dessert, whatever they may be.

The main meat for the day is planned for two weeks at a time and the accompaniments and dessert are discussed with the chef each day and approved. The chef does not require recipes as such, but follows his own standardized methods.

Mrs. Lucas' operation is located in a small, residential suburban community, with ample acreage for gardens and orchards, and near-by farm sources of poultry and eggs. Virtually everything in the way of vegetables, as well as eating and cooking fruits, is home grown and quick-frozen or canned for out-of-season service. Thus her local buying consists largely of meats, staple groceries, and a few commercially canned items.

She reports: "Ours is a privately financed operation, but out-of-line food costs and lack of control could easily put us in the red. We have basically the same food cost problem as Mr. Levinson – any institution must be vigilant to keep this under control.

"But we have a different clientele and a quite different staff complement, so it is sound, practical sense for us to grow and process much of our food, not only the vegetables per se, but all of our relishes, pickles, jams, jellies, vegetable juices, pie fillings. Some are canned or bottled; other products are frozen. We make a good deal of individual birthdays, and there is always a specially frosted and decorated birthday cake with ice cream for the occasion." Prebaked, frozen cake layers, freshly frosted, are highlights for the patients, and Mrs. Lucas finds they are no trouble to prepare. All of the nurses, in addition to the regularly employed cooks, are "good home cooks" and some of their close and affectionate relationship with the patients is developed through their participation in the food preparation and preservation activities.

"Actually, we treat our family as just that—a big family. The menu for the day is posted after breakfast and this is big news for the day as it would be at home. Among the aged and infirm, anticipation of the next meal, no matter how good the previous one has been, is part and parcel of getting better. We encourage it," Mrs. Lucas says.

The kitchen is a "big home kitchen" but built and equipped to the finest institutional standards. It was costly to do, but Mrs. Lucas believes she has saved the cost many times over, in reduced hours and less fatigue for the staff and herself.

The house physicians and other specialists who work with the staff agree that the days of feeding all soft or "invalid" foods to aging patients are over. Assuming that foods can be digested by individual patients, the staff sees no reason why pie should be taboo, or frankfurters. Rather than deprive the patient of some favorite food, the home makes the adjustments, *i.e.* frankfurters are well cooked, skinless and hot, and served with suitable vegetables.

"We are not in the least reluctant to serve home-fried potatoes, French fried vegetables, croquettes and the like. Poor fat and frying technics are more likely to cause indigestion than the fact that foods are fried or sautéed. We do not 'fry' meats," Mrs. Lucas says.

Like Mr. Levinson, Mrs. Lucas has no problems with leftovers, but for a different reason. In her home, certain foods are deliberately "leftover" to make them over into other dishes, but the staff has to cook double in order to do this—there is no "food rejection" to count on.

Breakfast is a light but substantial meal; the big meal is at noon, and supper is served early and is a light meal. There are careful provisions for between-meal supplemental feedings: high calorie or low calorie soft drinks, eggnogs, cereal bran with milk, gingerale, citrus juices, judicious "doles" of hard candy, fresh fruit, crackers, and of course whole or skim milk to drink, on demand, at any time.

Patients who cannot feed them-

Photograph, Courtesy Ac'cent International.

Hungarian stew, properly seasoned, has the advantage of providing good nourishment and being good to eat.

HUNGARIAN STEW

Yield: 2 gallons, approx. *Portions: 32 one-cup servings (8 oz.)*

- 4 lbs. beef chuck, cubed
- 2 lbs. lean veal, cubed
- 2 lbs. lean pork, cubed
- 2 tablespoons monosodium glutamate
- 1 cup all-purpose flour
- 3½ teaspoons salt
- Scant teaspoon pepper
- ½ cup fat, for browning
- 2½ quarts boiling water
- 2 large grated onions
- 3 cups thick sour cream
- ¼ cup chopped parsley
- 2 teaspoons celery salt
- 1 tablespoon paprika

Shake monosodium glutamate over combined meat cubes. Combine flour and seasonings; distribute over meat. Toss and mix together to coat each piece. Brown floured meat in hot fat in heavy kettle. Add water. Cover; simmer gently about two hours or until meat is tender. Add onion. If stew is too liquid, uncover and cook down to reduce liquid, or take off liquid to use for cooking noodles. Add remaining ingredients; blend well. Simmer 15 minutes.

Serve stew with cooked noodles. Use any liquid (broth) taken from the cooked meat, together with additional water or stock, for cooking noodles according to package directions.

selves are served first; these meals range from macerated and liquefied complete meals, fed through a tube, all the way to the "second helping" regulars in the dining room.

Menus are made up for a month at a time: the first two weeks in detail, the succeeding two weeks with the main dish or meat and one basic vegetable sketched in. At the same time withdrawal notations are made for items to be brought from freezer storage for defrosting and items to come from the root cellar and canned food storage shelves. Except at times of withdrawal, these storage areas are kept locked.

When an individual's diet requires an extra egg, more or less of some food, reduced salt intake, and so on, the adjustment is posted at range and serving unit. The cook and the tray arrangers quietly adjust the special tray setup or the plate portions so that no attention is called to the patient's modifications.

The recipes have been standardized for the size of the group, and to ensure good results no matter who happens to get the preparation assignment for the day.

"We use monosodium glutamate to help make our food so tasty that the patients will enjoy it. What is more important, if they enjoy it, food is more beneficial to them. Second, the extra glutamic acid which results from metabolism seems to help our patients," Mrs. Lucas says.

HOSPITALS

CAFETERIAS

SCHOOLS

TRANSPORTATION LINES

Normandy

One of 23 Open Stock Patterns
In Syracuse China's
Hospitality Group
Packed in cartons — Ready to ship

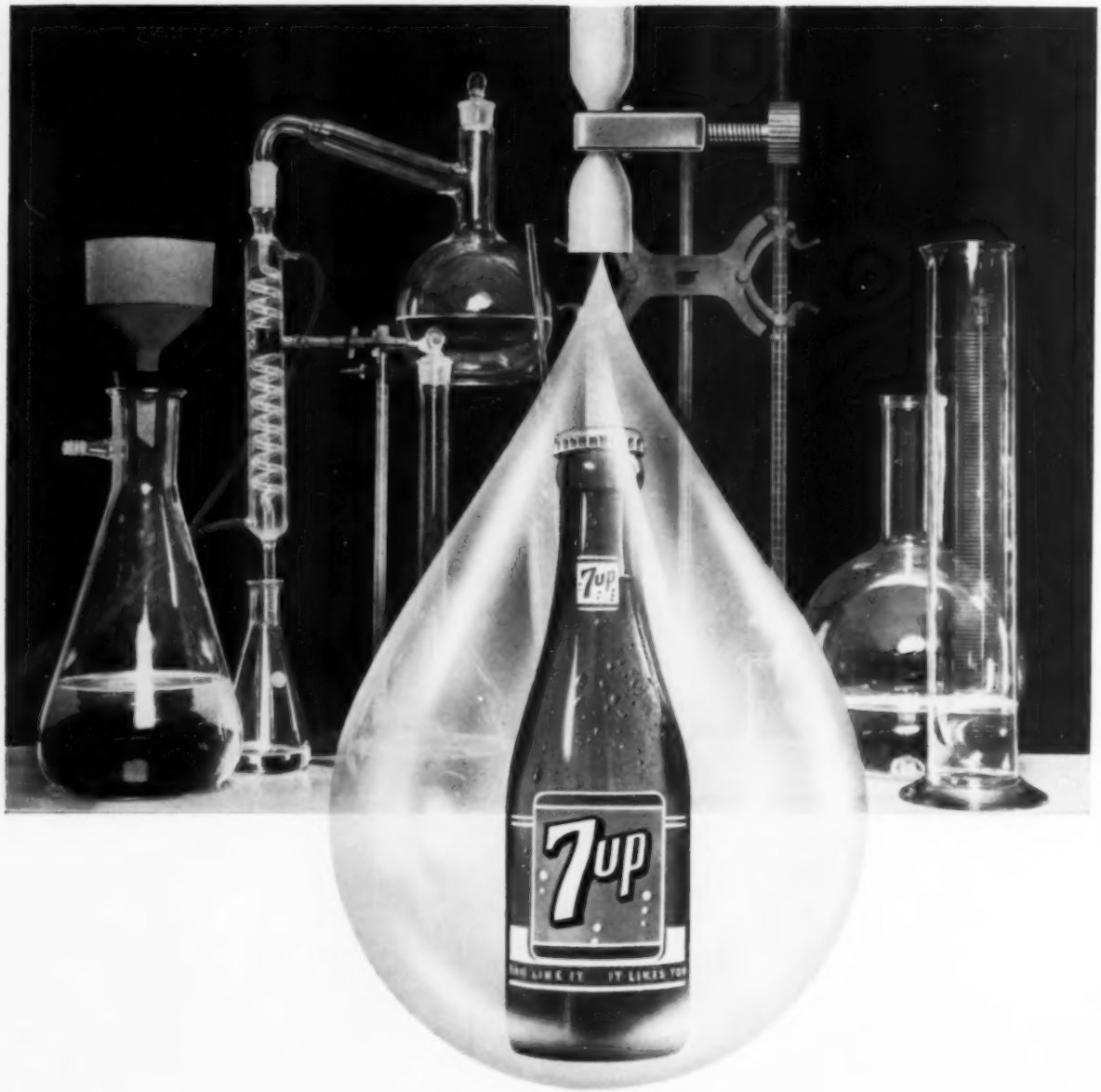
For space-saving cost-cutting efficiency...

With Syracuse's Trend Shape Normandy service, you can get the same number of pieces on a 10½" x 15" tray that would require a 16" x 22" tray when using conventional shapes. Trend Shape increases food service cart capacity. Features perfect portion control. It's perfectly weighted and very strong. Syracuse China stands up better in actual use than any other china or china substitute.

No other line of china can match the beauty and performance of Syracuse

SYRACUSE China
SINCE 1871
SYRACUSE, NEW YORK

For descriptive literature write Dept. N-1



We use high-purity water ... to protect the quality of 7-Up!

We start with drinking water approved by the U.S. Public Health Service. But 7-Up goes several steps beyond their critical standards.

All 7-Up bottling plants employ a complex maze of filters and purifiers which improve the water—before it's used in 7-Up. Removed are those parts that cause turbidity, odor and "off" taste. While biologically harmless, they have no place in 7-Up . . . a soft drink prized for its crystal clarity and fresh, clean taste.

Water so purified is odorless, colorless and tasteless. There's nothing in it to alter the true flavor of 7-Up.

That's why 7-Up tastes exactly the same every place—fresh, clean—no matter where you uncap the familiar green bottle.

Nothing does it like Seven-Up!

ONE CONVEYOR...MANY TOP ARRANGEMENTS

All-purpose food conveyor provides interchangeable insets for various menus

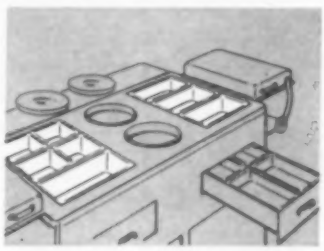
• You are ready for every food service requirement with Blickman-Built all-purpose food conveyors. Simply arrange the different sizes of square and rectangular insets in the top deck to suit the menu. For general service, you store the relatively limited variety of foods in larger insets. To handle the more diversified foods in selective menus and special diets, you replace the larger insets with a greater number of smaller ones. Round wells are also provided for soup, broth and potatoes.

• Seamless top and crevice-free body is standard construction in all Blickman-Built stainless steel food conveyers. These features offer notable benefits in sanitation and durability.

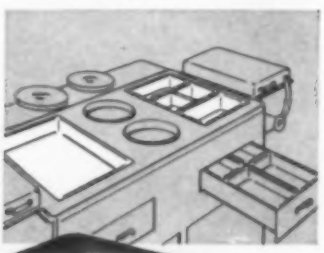
• The new Hi-Flo heating system cuts preheating time in half, assures piping hot foods for your patients.

A full complement of square and rectangular insets provides food storage for a wide variety of menus.

Rectangular wells accommodate a variety of inset combinations.



Another possible arrangement for top deck. Heated drawer holds special diet insets. Round insets are for soup, broth or potatoes.



Another variation showing use of one full-size pan at left and four insets in right-hand well.

All-Purpose Model ALS-4922
Long shelf and two rectangular pan covers provide work surface for loading trays.

SEND FOR CATALOG
Blickman-Built all-purpose food conveyors are fully described in our new Catalog T-5. Also shown are a wide selection of bulk food and tray conveyors designed for various types of decentralized and centralized services. Write for your copy today.

S. BLICKMAN, INC.
1503 Gregory Avenue
Weehawken, N. J.

Visit us at NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, Mass. Booth #78 March 24-26.

Look for this symbol of quality... Blickman-Built

BLICKMAN
FOOD SERVICE EQUIPMENT

Menus for April 1958

Marie L. Sopp
Head Dietitian
Billings Deaconess Hospital
Billings, Mont.

1 Orange Wedges Bacon Curls • Cubed Steak Rhode Island Potatoes Broccoli With Lemon Butter Peach Salad Spice Cupcake, Caramel Icing • Cream of Corn Soup Stuffed Peppers Carrot Strips Lettuce Slice With Ripe Olive Dressing Glazed Baked Apple	**2** Pineapple Juice Soft Cooked Egg • Pot Roast With Onion Gravy Mashed Potatoes Mixed Vegetables Grapefruit, Endive Salad, French Dressing Plum Cobbler • Fruit Punch Escalloped Turkey and Dressing Asparagus Molded Cranberry Salad Sugar Cookies	**3** Stewed Prunes Sausage Pattie • Breaded Pork Chop Orange Glazed Sweet Potatoes Buttered Peas Fruit Kabob Salad Lemon Fluff • Vegetable Soup Beef Biscuit Roll, Gravy Green Beans Garden Salad With Oil and Vinegar Chocolate Ice Cream	**4** Tomato Juice Scrambled Eggs • Ocean Perch, Lemon Baked Potato Creamed Carrots Red and White Slaw Pear Crisp • Cherry Lemonade Baked Macaroni and Cheese Broccoli Orange Waldorf Salad Iced Ginger Creams	**5** Appleberry Sauce French Toast, Sirup • Stuffed Meat Loaf Mashed Potatoes Harvard Beets Apricot Surprise Salad Toffee Bar • Chicken Soup Loin Steak Baked Lima Beans Tomato Wedges With 1000 Island Dressing Custard	**6** Orange Juice Fried Egg, Bacon • Baked Ham With Mustard Sauce Escalloped Potatoes Asparagus Spears Pear Salad Cherry Sherbet • Consommé Veal Scallopine Browned Rice Stuffed Celery and Olives Lemon Meringue Pudding
7 Banana Soft Cooked Egg • Roast Beef, Gravy Parsley Potato Balls Spinach Fruit and Cottage Cheese Salad Toasted Cocoanut Pie • Split Pea Soup Swedish Meatballs Buttered Squash Tossed Salad, Dressing Pineapple Chunks	**8** Blended Citrus Juice Poached Egg • Breaded Veal Cutlet Mashed Potatoes Escalloped Tomatoes and Celery Carrot, Raisin Salad Sponge Cake With Orange Icing • Cranberry Cocktail Chicken Pot Pie With Biscuits Green Beans Fruit Medley Salad, Honey Cream Dressing Chocolate Drop Cookies	**9** Red Plums Scrambled Eggs, Ham • Meat Pattie With Creole Sauce Baked Potato Whole Kernel Corn Lettuce With Roquefort Dressing Deep Dish Cherry Pie With Spiced Cream • Cream of Potato Soup Roast Beef, Gravy Paprika Cauliflower Stuffed Nectarine Salad, Dressing Strawberry Ice Cream	**10** Apple Juice Bacon Curls • Turkey, Noodle, Mushroom Casserole Broccoli Fresh Citrus Salad With French Dressing Date Bars • Tomato Soup Grilled Cheese Sandwich Potato Chips Raw Vegetable Relishes Green Grapes in Sirup	**11** Stewed Peaches Cinnamon Toast • Fillet of Sole, Tartare Sauce Buttered Potato Mixed Vegetables Waldorf Salad Boston Cream Pie • Vegetable Soup Salmon Croquettes Creamed Peas Marinated Green Bean and Onion Salad Angel Food Cake	**12** Grapefruit Juice Pancakes, Sirup • Baked Spareribs, Dressing Mashed Potatoes Asparagus Spiced Pear Salad Milk Chocolate Pudding • Limeade Hamburger on Bun, Ketchup Hot Potato Salad Sliced Tomatoes and Pickles Gingerbread With Whipped Cream
13 Sliced Oranges Sausage Links • Fried Chicken With Giblet Gravy Whipped Potatoes Matchstick Carrots Molded Gingerale Salad, Dressing Creme de Menthe Ice Cream • Consommé Madrilene Veal Fricasse Stuffed Baked Potato Lettuce With 1000 Island Dressing Lemon Cheese Pudding	**14** Pineapple Juice Scrambled Eggs • Roast Lamb With Gravy and Mint Jelly Parsley Potatoes Seven-Minute Cabbage Stuffed Prune and Orange Salad Dutch Apple Cake, Sauce • Grape Ale Spaghetti With Meat Sauce, Cheese Wax Beans Tossed Salad, French Dressing Golden Pears	**15** Grapefruit Half Poached Egg • Ham Balls Escalloped Potatoes Broccoli, Lemon Butter Lettuce With Dressing Vanilla Pudding • Fruit Punch Cold Sliced Meat Kidney Bean Salad Vegetable Jackstraws Cranberry Oatmeal Square, Whipped Cream	**16** Vegetable Juice Bacon Curls • Pot Roast, Gravy Mashed Potatoes Buttered Cauliflower Celery Pimwheel Salad Double Deck Brownie • Chicken Rice Soup Stuffed Pork Chop Corn Pudding Grapefruit, Apple Salad, French Dressing Lemon Sherbet	**17** Figs in Sirup Fried Egg • Meat Pie, Biscuits Buttered Potato Balls Buttered Peas Coleslaw Pear Butterscotch Crisp • Apricot Nectar Cubed Steak Green Beans Creole Orange, Grape Salad Iced Cupcake	**18** Blended Juice French Toast, Jelly • Scallops With Lemon Baked Potatoes Creamed Vegetables Green Salad With Oil and Vinegar Norwegian Prune Pudding With Whipped Cream • Manhattan Clam Chowder Tuna Loaf, Parsley Sauce Buttered Asparagus Cheese Straws Relishes Green Gage Plums, Sirup
19 Pineapple Juice Soft Cooked Egg • Liver and Bacon Escalloped Potatoes Buttered Spinach Peach, Cottage Cheese Salad Nesselrode Pie • Grape Juice Frankfurter on Bun, Mustard Macaroni Salad Sliced Tomatoes Macaroons	**20** Applesauce Bacon Strips • Roast Turkey, Gravy Whipped Potatoes Baby Lima Beans Molded Cherry Salad, Dressing Caramel Ice Cream • Cream of Mushroom Soup Spanish Steak Buttered Carrot Rings Tossed Salad With French Dressing Fresh Fruit Cup	**21** Orange Juice Scrambled Eggs • Grilled Ham Slice Baked Sweet Potato Buttered Cauliflower Pineapple Ring Salad Cranberry Tapioca Pudding • Consommé Beef Kabobs on Rice Sliced Beets Lettuce Slice With 1000 Island Dressing Lemon Fluff	**22** Stewed Prunes Poached Egg • Beef Stew With Vegetables Buttered Potato Peach and Pear Salad With Dressing Boston Cream Pie • Apple Juice Sausage Links Corn Pancakes, Sirup Grapefruit, Endive Salad Green Grapes	**23** Tomato Juice Fried Egg • Breaded Veal Cutlet, Cream Gravy Mashed Potatoes Buttered Peas Stuffed Apricot Salad Mocha Cake • Cream of Vegetable Soup Beef Pattie in Bacon Buttered Squash Green Salad, Dressing Blueberry Crisp With Cinnamon Whipped Cream	**24** Banana Pancakes, Sirup • Cubed Steaks au Gratin Potatoes Buttered Broccoli Carrot, Raisin, Pineapple Salad Orange Tapioca Pudding • Cranberry Cocktail Ham Croquette With Celery Sauce Mixed Vegetables Fruit Medley Salad Parker House Roll Brown Sugar Cookie, Burnt Butter Icing
25 Tangerine Juice Soft Cooked Egg • Golden Halibut, Tartare Sauce Baked Potato Beets in Orange Sauce Apple and Date Salad Gelatin Whip With Fruit • Tomato Bisque Mountain Trout With Lemon Wedge Asparagus Spears Celery and Pickles Iced Fudge Bar	**26** Grapefruit Sections Bacon Curls • Stuffed Meat Loaf Buttered Potato Buttered Spinach Olive Coleslaw Pumpkin Cake • Lemon Limeade Lamb Chops Baked Tomatoes With Cheese Pear, Mint Jelly Salad Hungarian Nut Torte	**27** Pineapple Juice Coffee Cake • Roast Pork, Gravy Pink Applesauce Oven Browned Potatoes Green Beans Soufflé Fruit Salad Lime Sherbet • Bouillon Beef Biscuit Roll With Mushroom Sauce Parsley Buttered Carrots Shredded Lettuce, Oil and Vinegar Orange Sections, Custard Sauce	**28** Dried Fruit Compote Fried Egg • Swiss Steak Mashed Potatoes Whole Kernel Corn Vegetable With Cottage Cheese Salad Cherry Cocoanut Square • Fruit Punch Braised Short Ribs Buttered Noodles Tomato Wedges, Ripe Olives Date Butterscotch Pudding	**29** Orange Wedges French Toast, Sirup • Chicken Supreme Parsley Biscuits Baby Lima Beans Pear, Tokay Grape Salad Strawberry Shortcake With Whipped Cream • Beef Barley Soup Breaded Veal Cutlet Stuffed Baked Potato Tossed Salad With French Dressing Red Plums in Sirup	**30** Vegetable Juice Poached Egg • Swedish Meatballs Mashed Potatoes Peas and Mushrooms Pickled Beets, Celery Curls Fruit, Marshmallow Cream • Corn Chowder Grilled Ham Mashed Sweet Potato Waldorf Salad Angel Food Cake

Ready-to-eat or cooked cereals served on all breakfast menus.

Result: New products that offer new economies

These recent Lily developments help you speed up service—with less effort, at less cost.

The Man With The Lily Plan is tackling a problem—so he can help drop your costs to a minimum. Such unrelenting efforts have provided volume feeders with a cost-conscious team of new products, plus important improvements on proven products.

For example, Lily* place settings (shown in kit) offer all kinds of economies—from soup to nuts. They're completely disposable, thus eliminating labor costs involved in scraping, washing, drying and storing. They also eliminate need for dishwashers, expense of maintaining them, and additional cost of hot water, soap and detergents.

Simplify service, lighten trays

Lily place settings provide a matched service for nearly every food and beverage on your master menu. They require less storage space, eliminate the expensive problem of breakage, cut time and effort involved in bussing. Lily paper service also simplifies serving and after-service.

Volume feeders of all kinds use Lily place settings to save valuable time, and to reduce fatigue caused by carrying heavy, dish-laden trays.

New Lily exclusive

Lily offers three sizes of molded smooth plates: 6, 9, and 10 in., plus two sizes of compartmented molded plates, 9¼ and 10¼ in. The 9¼ in. plate, made by Lily alone, has that extra rigidity needed for confident one-hand handling. Its "full depth" compartments control portions and costs better, keep foods and companion juices and gravies in place. 10¼ in. plate has same features but allows for larger portions.

Free samples

Lily is constantly striving — through research, through product development, through product improvement — to find new economy measures, new convenience features. We'd be happy to show you how specific findings apply to your operation. We'd also be happy to send you free samples of the products above. Just write: *Lily-Tulip Cup Corporation, Dept. MH 3, 122 East 42nd Street, New York 17, New York. *T.M. Reg. U.S. Pat. Off.*

We Spent $2800 to Save $1800 per Year

By installing a capacitor, this hospital uses less current to do the same work, and also is charged a lower rate by the company supplying the electricity

R. A. BRADBURN

WOULD you spend money to save money? We did, by changing our power factor from 80 per cent to 100 per cent. This 20 per cent differential to date has saved, on the average, $1800 per year on our electric bill. The $2800 represents the cost of purchasing and installing electrical capacitors.

To the average hospital administrator, the term power factor is a foreign language. The term arose because in alternating current circuits the energy supplied to motors, transformers and other such equipment is composed of two kinds of current. One is power producing (working current), which is converted by the equipment into useful work. The other is magnetizing current (reactive current), which is needed to magnetize inductive equipment before it will operate and while it is operating. This magnetizing current is not converted into useful work, but it is necessary in order for the equipment to utilize current to produce power. Power factor simply expresses the ratio of power or working current to the total current.

In the example, the load draws 100 amperes from the supply, but because part of the current is consumed by magnetizing requirements, only 80 amperes are actually converted into useful work. In this instance, the power factor is 80 per cent or, as it is often expressed, eight-tenths.

It is evident that if magnetizing current could be reduced in some fashion, the total current consumption could be reduced. Since less current would be needed to provide the same circuit with the same power for the same load, to improve the power factor you simply neutralize or eliminate the magnetizing current by supplying it at, or near, the motor source. Therefore, all incoming current is used for working current, and the power factor becomes unity, or 100 per cent.

The supplying of this magnetizing current is easily, quickly and inexpensively done by the installation of capacitors. These capacitors are generators of magnetizing current required by the electrical equipment. When they are located near the equipment, they furnish the magnetizing requirement direct, thus wasting none of the power producing current in nonproductive work.

If the total motor load of a circuit is 80 amperes, after the capacitor has been installed the working current drawn would be 80 amperes. Prior to the installation of a capacitor, the total current drawn would have to be 100 amperes, because 20 amperes of the 100 would be used to supply the magnetizing current of the load.

The costs savings come from two separate sources. One is the reduction in the total amount of power consumed. The other is that public utilities, on demand billing basis, measure energy requirements from generating and distribution equipment. The power factor of the utilizing equipment is taken into consideration, as well as direct wattmeter readings. Rate sched-

Mr. Bradburn is the administrator of Memorial Hospital, St. Joseph, Mich.

Exhibit 1

Below: The work load draws 100 amperes from the supply circuit. But because 20 amperes are consumed by the magnetizing requirements, only 80 amperes are converted into useful work.

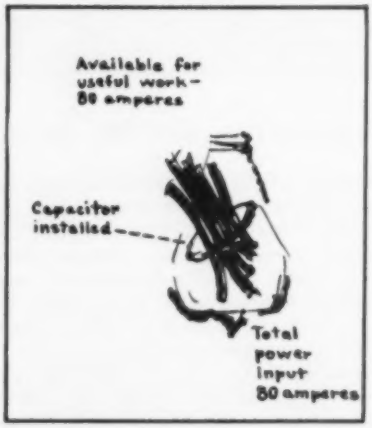


Exhibit 2

Above: Here, the 20 amperes for magnetizing requirements are supplied by capacitor; so only 80 amperes need be drawn from supply circuit to produce same amount of work as in Exhibit 1.

Let's not clean away dollars and man-hours with costly, inadequate floor care

MECHANIZE *your floor-cleaning with a* COMBINATION SCRUBBER-VAC!

(Powder Dispenser and Level Cable Wind are accessories)

Wherever *combination-machine-scrubbing* is the practical solution to the floor-cleaning problem, any lesser, slower method is wasteful of money and manpower. A *Combination Scrubber-Vac* applies the cleanser, scrubs, flushes if required, and picks up (damp-dries the floor)—*all in one operation!* Maintenance men like the convenience of working with this single unit . . . the thoroughness with which it cleans . . . and the features that make the machine simple to operate. It's *self-propelled,* and has a *positive* clutch. There are no switches to set for *fast* or *slow* — slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs quietly. Cable reel is self-winding. *Finnell's 213P Scrubber-Vac* at left, an *electric* unit for heavy duty scrubbing of large-area floors, has a 26-inch brush spread. Cleans up to 8,750 sq. ft. per hour (and more in some cases), depending upon condition of the floors, congestion, et cetera. (The machine can be leased or purchased.)

Finnell makes *Scrubber-Vac Machines* in a full range of sizes, and *gasoline* or *propane powered* as well as *electric* models. From this complete line, you can choose the size and model that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that *a Finnell Floor Specialist and Engineer is nearby* to help train your maintenance operators in the proper use of the machine . . . to recommend cleaning schedules for most effectual care . . . and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 1403 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

Everything for Floor Care — FINNELL

BRANCHES IN ALL PRINCIPAL CITIES

Electric Power Consumption Costs

	Month	Power Cost	Adult Patient Days	Power Cost per Patient Day
1955	Monthly Average	$ 1,069.92	2178	$0.491
1956	January	1,110.50	2746	0.404
	February	1,091.25	2436	0.448
	March	1,010.70	2595	0.390
	April	975.20	2366	0.412
	May	1,003.10	2715	0.369
	June	1,176.80	2401	0.490
	July	1,003.70	2241	0.448
	Capacitors Installed			
	August	997.67	2437	0.409
	September	952.50	2117	0.450
	October	875.40	2193	0.399
	November	879.25	2421	0.363
	December	892.08	2533	0.352
Totals		$11,968.15	29,200	
	12 Months Av.	$ 997.35	2433	$0.411
	1st 7 Months Av.	1,053.04	2500	$0.423
	Last 5 Months Av.	919.38	2340	$0.394
1957	January	$ 931.78	2951	$0.316
	February	889.57	2593	0.343
	March	865.52	2615	0.331
	April	824.45	2303	0.358
	May	881.15	2654	0.332
	Last 10 Months Av.	$ 898.94	2482	$0.365

Table of electric power consumption costs at Memorial Hospital shows savings made possible by installation of capacitors, despite increase in patient days.

ules are adjusted accordingly, with premiums for high power factor and penalties for low power factor. These rate schedules take various forms, each designed to suit local conditions of power generation distribution and consumption. Thus, not only is less current utilized but the rate paid for the current is decreased as the power factor rate increases up to 100 per cent.

In our own case, our primary power supplier, the Indiana-Michigan Electric Company, called to our attention the fact that improvement of our power factor would result in sizable savings in monthly electric power costs. Engineers from the company recommended the size of capacitors to be installed and suggested their locations. We obtained bids from several electrical contractors for the equipment and installation. The contractors concurred with the power company recommendations on the size and placement of the capacitors. Installation was made in July 1956, and, as may be seen from the table on this page, a substantial reduction in power cost has been made from that date on. This reduction occurred in spite of the fact that our volume of business has been increasing throughout the period shown.

The average monthly power cost for the first seven months of the year 1956 was $1,053.04. The average patient days for the same period was 2500, with a per patient day power cost of $0.423. The average monthly power cost for the year 1955 was $1,069.92, with an average number of patient days of 2178, or an average power cost per patient day of $0.491. For the 10 month period from Aug. 1, 1956, to May 31, 1957, the average monthly power cost was $898.94, which represents a savings of $154.10 from the average power cost for the first seven months of 1956. This savings, multiplied by 12 months, would mean an annual savings of $1,849.20. The number of adult patient days for the similar 10 month period is 2482, with an average per patient day power cost of $0.365.

Because of the savings in power costs at this institution, hospitals which do not presently have capacitors in use might benefit from investigation of such an installation.

For technical information contained in this report, I am indebted to the Indiana-Michigan Electric Company and the General Electric Company, manufacturer of Pyranol capacitors.

when this TROY unloading washer goes to work

The superior quality of Troy equipment shows itself in this unloading washer through rugged stainless steel construction and advanced washing features.

Semi-automatic control is standard — no more old fashioned inlet valves or foot operated outlet valves. On Troy Unloading Washer, both inlet and outlet valves are operated automatically — electronically. In addition, fully automatic controls are available, both with and without supply injection. And remember, all Troy cylinder perforations are embossed.

Ask your representative about Troy Unloading Washers or get complete details by mailing the coupon today!

SEE OUR CATALOG IN SWEET'S ARCHITECTURAL FILE OR WRITE FOR COPY

Troy

LAUNDRY MACHINERY

Division of

American Machine and Metals, Inc.

EAST MOLINE, ILLINOIS

"World's oldest builders of power laundry equipment"

NEW! Bulletin gives valuable information on construction, features, dimensions and specifications.

MAIL COUPON TODAY

TROY LAUNDRY MACHINERY, DEPT. MH-358
Division of American Machine and Metals, Inc.
East Moline, Illinois

Without obligation, please send bulletin YW-42-57 describing TROY Unloading Washers.

COMPANY

ADDRESS

CITY ZONE STATE

ATTENTION MR.

A Training Program for Housekeepers

12. Teaching Is a Continuing Process

BARBARA D. MILLS

TRAINING must, of course, begin at the supervisory level. Then personnel must be educated to adapt to changes. This usually involves changes such as scheduled distribution of the work load, assignment of responsibility, and the opportunity to participate. (Note I did not say "delegate" responsibility.)

This type of departmental structure encourages cooperation on the part of all personnel, which is most helpful in any undertaking. Remember, you can pull a string, but you can never push one.

Policies and procedures with training administered in regular doses should be definite requirements of the job. Every skilled workman takes excellent care of his tools. Therefore, just being interested in the handling of personnel is not enough. You must be watchful for roadblocks in the functioning ability of both the departmental and organizational policies and procedures. It will mean establishing a condition of balance, and that the employes accept the state of balance.

Do you put across your ideas? The biggest step toward success in the development of your tools will depend on the effectiveness with which you put across your ideas or the unit of instructional material.

Encourage employes to achieve these objectives through stimulating discussions on the new training technics. Good training develops through a series of progressive experiences, the ability on the part of the new worker to do something he could not do before.

Finding personnel unresponsive to your influence as a leader is equivalent to the nonpolicy approach. People just won't learn anything unless you can divorce them of their prejudices and feelings; free them from the frustrations of trying something new through the medium of anticipation and acceptance on their own.

To me there is nothing more important in helping a beginner, either in the organization or in some new procedure, than being sure that his instructions, as well as his supervisor, start him out with adequate understanding. Job knowledge will develop good working habits and high standards.

Employe meetings for the most part are enjoyed by all if they are given an opportunity to have a voice in the discussion. Silence means questions or lack of understanding and is most unhealthy, plus the fact that it usually means your words went in one ear and out the other. You cannot cope with silence.

I am not trying to give you the impression that it is possible to teach everybody everything, for we all know there are certain mental limitations that must be recognized and that the necessary, or minimum, intelligence is a must to meet job requirements no matter how skilled the presentation may be.

Training at its best takes many hours of *labour* in preplanning the outlines of presentation. I spelled it labour, rather than labor, because it is harder when you have to put *you* in it. If every new worker had to learn his duties by trial and error, the supervisory personnel would be so busy correcting mistakes that there would be little time left to prevent

Three graduates of Mrs. Mills' training program for executive housekeepers receive diplomas from Joseph P. Greer, administrator of St. Luke's.

This is the twelfth and concluding lecture on training executive housekeepers in the series begun in the March 1957 issue of The MODERN HOSPITAL. The course was prepared by Mrs. Mills while she was director of housekeeping services at St. Luke's Hospital, Chicago. She is now director of housekeeping services at Allegheny General Hospital, Pittsburgh.

Everything Looks Better

EVERYONE FEELS BETTER

Typical hospitals kept beautiful *at a saving* with Pratt & Lambert Products

HOSPITAL FOR SPECIAL SURGERY
New York City, New York

LANKENAU HOSPITAL
Overbrook, Philadelphia, Pennsylvania

MEMORIAL & CRIPPLED CHILDREN'S HOSPITAL
Roanoke, Virginia

FRAMINGHAM UNION HOSPITAL
Framingham, Massachusetts

BARNARD SKIN & CANCER HOSPITAL
St. Louis, Missouri

ST. LOUIS MARIE de MONTFORT HOSPITAL
Ottawa, Canada

HENRY FORD HOSPITAL
Detroit, Michigan

HOSPITAL HOTEL DIEU
St. Catherines, Ontario

CHATHAM MEMORIAL HOSPITAL
Savannah, Georgia

MATERNITY SHELTER HOSPITAL
Greenville, South Carolina

TEMPLE UNIVERSITY MEDICAL CENTER
Philadelphia, Pennsylvania

ST. LUKES HOSPITAL
Saginaw, Michigan

JOSEPH MERCY HOSPITAL
Centerville, Iowa

TABER MUNICIPAL HOSPITAL
Taber, Alberta, Canada

Fresh, cheery *color* gives a welcome "lift" to your building and everyone in it. You can have exquisite colors in combinations that harmonize perfectly...with Pratt & Lambert *New* Lyt-all Flowing Flat... the finest alkyd flat enamel for walls and ceilings. Your color selection is made easy and unerring by Pratt & Lambert's exclusive system of Calibrated Colors.®

COSTS LESS TO APPLY *New* Lyt-all Flowing Flat goes on easily and smoothly, hides exceptionally well. You can cover more surface with less of it! And there's no objectionable odor, either. Rooms can be put back in service much sooner when you use Pratt & Lambert *New* Lyt-all Flowing Flat.

COSTS LESS TO MAINTAIN It gives walls a rich velvety finish that stands up under repeated scrubbings. Patients, staff and visitors will be grateful for your decision to bring color into their rooms. Ask administrators of hospitals where Pratt & Lambert is used.

Or send the coupon for helpful color-selection material.

Mail coupon today. Check one or both boxes.

PRATT & LAMBERT, INC., Dept. I.
75 Tonawanda St., Buffalo 7, N. Y.
In Canada: 254 Courtwright Street, Fort Erie, Ontario.

☐ Please send me free color cards. ☐ I would like color suggestions by a trained Pratt & Lambert representative.

NAME _____

ADDRESS _____

CITY _____ STATE _____

M2

PRATT & LAMBERT-INC.

A Dependable Name in Paint Since 1849

NEW YORK · BUFFALO · CHICAGO · FORT ERIE, ONTARIO

errors through supervision. To accomplish this you must dig deep. You can't give just 15 minutes to constructive training without having to spend eight hours explaining something you should have done better the day before.

When I hear you remark, "I don't have time to train," you are, as a rule, also guilty of haphazard assignment and control. When this happens, the leader is kept busy overcoming mistakes or "putting out fires" that, had employes been properly trained in the first place, should not have happened. Training is not something to be given at odd moments or when a crisis arises. It should be continuous and play a vital part in the development of your employes. Give them a feeling of growing to do the job better.

Remember that enthusiasm is contagious. Deadpan presentations are very negative. Usually your employes can dispense their own gloom on the slightest provocation, but, by the same token, they can soak up a vast amount of enthusiasm and optimism if you can only feed it to them.

SPEED IS NOT A FACTOR

Through training, employes fall in step with the established procedure, wherein the timing is geared to meet demands of a particular job. Impress upon them that speed is not a factor: Doing the job right is more important than getting it done quickly. The outcome in performance of any job is the grand total of the various details. The quality of an individual's workmanship may be nothing more than his care and attention to details that had been entirely overlooked by a co-worker doing the same job.

However, don't excuse your own lack of patience and understanding by placing the blame on the "dumbness" of the individual. You will not improve your skill in training by using these tactics, for it is your responsibility as a trainer to get your ideas across. When I find myself running into this type of situation it is, in most instances, the result of failure to put myself in the other person's position. I have failed to locate the experience level of the individual, and I end up with my instructions going far over his head.

The individual who knows the job best has difficulty explaining in detail what he does. In other words, the job has become a habit. On the other hand, the new worker when asked, "Do you understand?" usually says Yes, but too often it is only because he doesn't want to show his ignorance. In reality his job is becoming more and more complicated because of his inability to grasp or understand what he is hearing and seeing explained.

From this you can see that training is an extremely challenging task and, in fact, it is being recognized as one of the outstanding mediums through which we can fortify personnel with job skills, increase quality and quantity of production, and reduce the budget.

The following are a few of the results you will obtain within your department, and, of course, the over-all result will be better patient care.

1. Organized and planned work patterns, such as progressive cleaning.
2. Ability to accomplish more by utilizing motion and minutes efficiently.
3. Better salaries; less absenteeism and turnover.
4. Results of your creative ability: You can't make a silk purse out of a sow's ear, but you surely can dress it up!

If you will recall, in your lesson on training service personnel you were given an outline showing a pattern for this training. At the extreme left of the outline there was an area marked "specific goals." You can never go anyplace unless you establish your goals. Why try to motivate others if you have no incentive yourself?

Of course, I am taking it for granted that you have given your goals much thought and consideration and that down deep you feel they are right and justified. Your thinking may not be accepted at the moment, no matter how well presented, but hang on tight, roll with the punches, and before too long you will be able to get some results. Eventually you will get your foot in the door, and then proper timing will soon allow you to receive further consideration. Just because your goals are not accepted does not mean they should be forsaken. Accept it as a challenge. Live up to the quality of your potential. Don't be bitter—be better.

For the sake of discussion and the need for a pattern of goals, turn back to your notes and list the words you put down during your first lesson. You will find: "organization," "scheduled," "assigning," "participate," and "cooperation." We will consider these as our specific goals. Let us compare our goals with the final results. The actual wording may not be the same, but the over-all picture is what you were striving toward. Therefore, you no longer have a goal, but an accomplishment. Once again you are ready to achieve another goal. In the meantime, I trust you have not been looking back, but that you have been continually nourishing your creative powers or ideas and that you are ready for the next step.

Good Housekeeping Reduces Infections

(*Continued From Page 54*)

them out to patients every evening is certainly a potential means of transferring infection from one patient to another. Picture the large cart, piled high with blankets, being pushed down the corridor while the nursing staff takes extra blankets to each patient.

Mr. Jones, with a draining wound, is given a blanket and, during the night, contaminates it. It is picked up the next morning, along with the extra blankets from other patients, and all piled together in the linen storage area. The blankets may contaminate each other by direct contact or by air-borne contamination.

The next night the same procedure is followed. The blanket Mr. Jones contaminated the previous evening is given to a patient who has come in for some minor surgery and is considered a "clean" case. This "clean" patient may get an infection because this contaminated blanket was used on his bed.

This procedure can go on indefinitely and one hesitates to think of the state of the blankets after a few such trips.

Bedside utensils.—Utensils used by the patient, that is, bedpan, bath basin, and mouth cup, can be the means of transmitting infection if not properly cleaned and sterilized between uses by different patients.

Drinking glass and pitcher.—The water pitcher and drinking glass used by each patient are potential reservoirs of infection. Possibly these utensils are loaded on a cart, taken to the utility room or diet kitchen, cleaned with a common brush, loaded back on the cart, and returned to the patient. It may be that the pitcher and glasses are not returned to the same patients from whom they were taken. Washing by hand and cleaning with a common brush do not ensure satisfactory cleanliness. How much safer to wash these items in the automatic dishwasher where one can be sure they are adequately cleaned.

Toilet.—The toilet seat can prove hazardous in spreading cross infection. Possibly the use of a toilet is shared by two or more patients. One may have a draining area that comes in contact with the seat, thereby contaminating it. Another patient sits on the toilet seat and may become infected. A patient may contaminate the seat with feces or urine, or he may contaminate his own fingers in feces and then contaminate the fixtures.

Lavatory.—Handles of lavatory faucets can easily be contaminated by being used by so many different individuals, both patients and hospital staff. The proper type of hand controls and proper handwashing technic are means of guarding against these faucets becoming a source of contamination.

Door handle.—Door handles are another potential reservoir of infection since they are touched by so many people.

Draperies, curtains, shades.—Draperies, curtains, venetian blinds and shades, not only in patients' rooms but elsewhere in the hospital, may be great dust-catchers and if not properly cleaned and maintained can be a source of air-borne contamination. The daily cleaning procedure as well as terminal cleaning when the patient is discharged are of utmost importance in making sure that all of these areas mentioned are safe before being used by another patient.

A study was done to determine if these areas could be contaminated.

The patient room was cleaned by acceptable methods and bacteriological tests indicated that there were no pathogenic or disease-producing organisms present. Two ambulatory patients, each with proven staphylococcal infections in open wounds, were placed in the room and moved about freely. Within a matter of hours bacteriological tests showed that toilet seat, door handle, faucet handle, bed linen, bedside table, and drinking glass and pitcher, among other items, were all contaminated.

NURSING UNIT

Let us now consider the environment outside the patient room but in the nursing unit.

Bathing facilities.—Bathtubs, showers and sitz baths can all be contaminated by a patient and, if inadequate cleaning is carried out between use, these areas can become active reservoirs.

Suppose a patient with a draining boil is bathed in the tub. The next person scheduled to use the tub is a burn patient who must be guarded with vigilance lest the burn area becomes infected. Unless the tub is carefully and adequately cleaned the organisms from the patient with the boil may infect the burn patient using the tub.

Bacteriological studies have been made and staphylococcal organisms have been found in bathtubs after an infected patient has been bathed.

Findings like these remind us that we cannot be too careful in the cleaning methods we use in order to provide a safe environment for the patient.

Treatment rooms.—Utility rooms, treatment rooms, and medication areas all call for adequate cleaning methods both for the safety of the patient and the safety of our personnel.

Clean and soiled.—Separation of clean and soiled functions throughout the hospital is a basic necessary measure in preventing infection of a patient through use of contaminated supplies and equipment. Clean utensils and supplies may become contaminated if placed on the same work surface on which used articles have been placed.

Ice.—The supply of ice is another source of potential contamination. Many times one sees an ice making machine or container of ice in which the ice scoop is used to fill pitchers and ice bags; then the entire scoop is dropped into the supply of ice. Soon another employe comes along, picks up the scoop, uses it, drops it back into the ice, then someone may come along, reach in and get a piece of ice for himself. The handle of the scoop, touched by many individuals, may serve to contaminate the supply of ice which, in turn, may contaminate the drinking water of the patient.

The method used when ice is brought from a central supply to a nursing unit also bears careful scrutiny. How clean is the cart used to transport ice? How clean is the ice container? How clean is the ice machine with all its parts? How long since the ice storage bin has been emptied and cleaned?

OTHER SOURCES

We have considered the immediate environment of the patient and those areas in the nursing unit that may affect him directly or indirectly. Let's look briefly at other areas in the hospital and procedures carried out in these areas that also have an effect upon the safety of the patient.

Floors.—Traffic from the outside inevitably brings in dust and dirt from many places. Floors become dust laden and any movement on the floors stirs up dust which becomes air-borne. Anything dropped on the floor becomes contaminated. The housekeeping and nursing departments need to plan their schedule so that no cleaning is being done in an area at the same time patient dressings are changed. This is also one reason for planning the cleaning schedule in the nursery when the majority of babies are being fed by their mothers outside the nursery.

Cleaning equipment.—Cleaning equipment used throughout the hospital are tools to combat the spread of infection. The manner in which these tools are maintained is an indication of how well the battle against infection is being carried on.

If these cleaning tools, especially mops, are used day after day without adequate cleaning they become a means of *spreading* infection from one

More and more hospitals daily expect more and more uses of the New, all-utility HOSPITAL-RIGHT disposable paper containers by Sealright.

Created to fulfill every Hospital function demanded of them, these are the specially processed paper containers literally engineered for most efficient—convenient—economical food, laboratory, analysis and operating room functions.

More and more Hospital personnel are recommending HOSPITAL-RIGHT paper disposable containers after first use because they recognize their modern safety—convenience—utility-plus and amazing savings features. . . .

There's a HOSPITAL-RIGHT Trial Kit for your staff to Test . . . send for it Today!

SEALRIGHT SANITARY SERVICE

Sealright

Sealright-Oswego Falls Corporation, Fulton, N. Y.—Kansas City, Kansas—Sealright Pacific Ltd., Los Angeles, California—Canadian Sealright Co., Ltd., Peterborough, Ontario, Canada.

MH-358

SEALRIGHT CO., INC., FULTON, NEW YORK
Send us a HOSPITAL-RIGHT Trial Kit.

Name..... Position.....

Hospital.....

Address.....

City..... Zone..... State.....

area to another rather than preventing the spread of infection.

In addition, certain areas in the hospital, such as operating room, delivery room and nursery, call for special precautions to be taken in their daily and specialized cleaning. Individual mops for each of these areas are indicated. Otherwise the mop used in the corridor, then in the nursery, may carry infection *into* the nursery *from* the corridor.

In the same manner, a mop used to clean the floor in the operating room where a septic case has been cared for may simply transfer these organisms into another room if the same mop is used without being properly sanitized. This contaminated mop can shed organisms like a road sander.

Linen.—Linen is always a problem in the hospital, whether the laundry is located on the hospital grounds or the services of a commercial laundry are used.

Studies have shown us that, when soiled linen is agitated in any way, organisms are disseminated through the air. Therefore, any handling of soiled linen, whether on the nursing unit or in the laundry, must be carefully controlled.

The time-honored custom of rinsing diapers and stained linens from the nursery, nursing unit, delivery room and operating room is fraught with danger. Hospital laundry managers have told us that stains are more easily removed by placing linen directly in the washer from the linen hamper and carrying out a correct washing procedure than by having the personnel struggle with the messy task of soaking and rinsing diapers and linen either in the nursery or the utility or clean-up room.

Another procedure that presents a hazard is the practice of dragging damp hampers full of heavily contaminated soiled linen on the floor. When the floor dries, the organisms are embedded in the dust and dirt and, when scuffed, are sown like seeds in the air. Using the same cart to collect soiled linen and return clean linen without adequately sanitizing the cart is another questionable practice.

One may see a linen closet or room full of nice clean linen serving as a coat closet for the personnel. Wet coats, umbrellas, purses, sack lunches, and newspapers may be a source of contamination to the clean linen.

If a commercial laundry is used, where is the collection point for the soiled linen? How often is the linen picked up by the laundry? Where is the clean linen returned and where stored? This incident was observed in one hospital which uses a commercial laundry: The clean linen was delivered wrapped in paper. It was brought to the service entrance and dumped on the floor immediately outside the kitchen. From here it was placed on a stretcher, unwrapped, and put away. Several points of possible contamination exist here.

Misuse of all methods of cleaning, sanitizing and sterilizing is another area that we should examine very critically.

How many of us have looked into a water sterilizer and observed utensils only partially submerged in the water? How often have we relied completely on a chemical solution to sanitize something without proper preliminary cleaning? How many times do we add the cleaning agent to water by guess instead of by measurement? We may use a disinfectant indiscriminately without knowing if it is suitable for the type of article being cleaned. Such ineffectual practices may lull us into a false sense of security.

EMPLOYES

The physical well-being of the employe is of fundamental importance. The employe with a draining boil, an infected finger, or a cold may be the cause of infection among patients either by having direct contact with a patient or by causing contamination of equipment, utensils or air. Some instances have been reported where deaths among patients have resulted because one person in the operating room had a boil and cross infection occurred while the patient was in surgery. Infections among patients have been traced to someone working in the laundry with a draining boil. This was not due to direct contact with patients but because the clean linen sent to the nursing unit was contaminated before it left the laundry.

One of the original reasons for the wearing of uniforms by the hospital personnel was to lessen the chance of bringing in organisms from outside the hospital to the patient area. Scrub dresses worn in the nursery, delivery room, and operating room are worn for specific purposes. One wonders how effective aseptic technic is in the operating room when someone is seen wearing a scrub dress and cap in the dining room, on the bus, or standing on the street corner. This not only endangers the hospital but what about the home into which the scrub dress is being worn?

Employes have a right to be shown the correct way to carry out a procedure and to be told why such procedures are important. One doctor in discussing this problem talked about the return to the "old-time religion" of scrubbing the hands. This calls for two things: first, adequate, strategically placed and conveniently located handwashing facilities, and second, employes who have the established practice of using these facilities routinely, thoroughly and consistently because they understand the importance of clean hands and arms. When should a hospital employe wash his hands?—After going to the bathroom, after cleaning soiled areas and utensils, and after direct contact with patients.

When in doubt, "wash."

Preventive Credit Plan Helps Patients Pay Bills

(*Continued From Page 65*)

than 200 beds, we are able to do this. In a month's time, however, we average about 600 admissions. Private open accounts average about 200 in number, and ward open accounts average about 500. Naturally, these are not all collection problems but they must be reviewed and billed each month. Welfare and other agencies and insurance accounts must be watched and billed. We are responsible only for the follow-up billing on these accounts.

There are no set rules for dunning. Each patient's account is reviewed, and the billing we consider most effective for each card is sent out. We have about 10 types of printed notice plus many more that we type on the bills. Our billing methods are reviewed every few months to check their effectiveness.

Many ward accounts are paid on a monthly basis and we simply bill each month with a return envelope enclosed.

As yet, we have not used any budget books or similar payment plans but these seem to be a growing trend as hospitals realize that, when the patient pays monthly bills, the hospital is likely to be left out if its book is not there with others. No doubt this idea is difficult for hospitals to accept, but it is unavoidable if they wish to protect their interests.

Once we have established a patient's budget, we then know what he is capable of paying. We bill the patient until his account is paid, as politely yet as firmly as we can. If a patient keeps to his original agreement, he receives only a monthly statement.

No patient account is given to a collection agency until the person has been notified of our intention well in advance. If the patient makes a sincere effort to pay or to tell us why he cannot pay, we are satisfied.

We send as few accounts as possible to the collection agency but there are always some persons who will not heed anyone but a third party, the collection agency. On the other hand, we do not unduly delay sending an account to our collection agency, as it also cannot collect if the account is too old. It is up to us to know when we are wasting our effort.

NO ONE REFUSED HELP

Massachusetts Eye and Ear Infirmary is a teaching hospital closely associated with Harvard Medical School. No one who seeks our help is refused and we take many people who we know cannot pay their accounts. On a certain percentage of these we are aided by the community fund. The rest is taken from our special funds for the medically indigent. It is our responsibility to make sure that those most deserving receive help and to collect from those who are financially able to pay.

In keeping with our public relations policies, no letter to this department goes unanswered. If a patient writes us concerning his bill, he receives a letter back or a notation on his bill confirming his letter. If we say we will telephone within a certain time, we telephone, whether we have the information or not, so the patient doesn't think we have forgotten him. There is no such thing as unfinished business.

Each desk is kept neat and up to date so that when a patient makes an inquiry any staff member can handle it, should another be away from his desk. This saves time, as well as the patience of the people who come to us for information.

People come to Massachusetts Eye and Ear Infirmary from all over the world seeking help, and we feel that this department is as much a part of their recovery as any other.


no pain...
no memory...
no nightmare of fear

in pediatric anesthesia

PENTOTHAL by Rectum has proved invaluable as an aid to anesthesia in clinical studies comprising nearly 4,000 cases. Some of the advantages offered by the Rectal route:

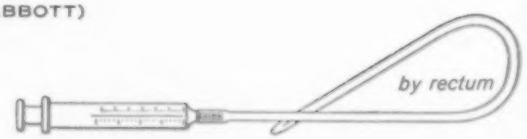
- a painless, reliable and simple method
- as a premedication, prevents emotional trauma in children
- lessens dosage of inhalation agents, reduces postoperative nursing care

Used as a basal anesthetic or as the sole agent in selected minor procedures, PENTOTHAL by Rectum is a notably safe, versatile and humane method in pediatric anesthesia. Abbott

PENTOTHAL®

Sodium

(THIOPENTAL SODIUM, ABBOTT)




STONEWALL JACKSON

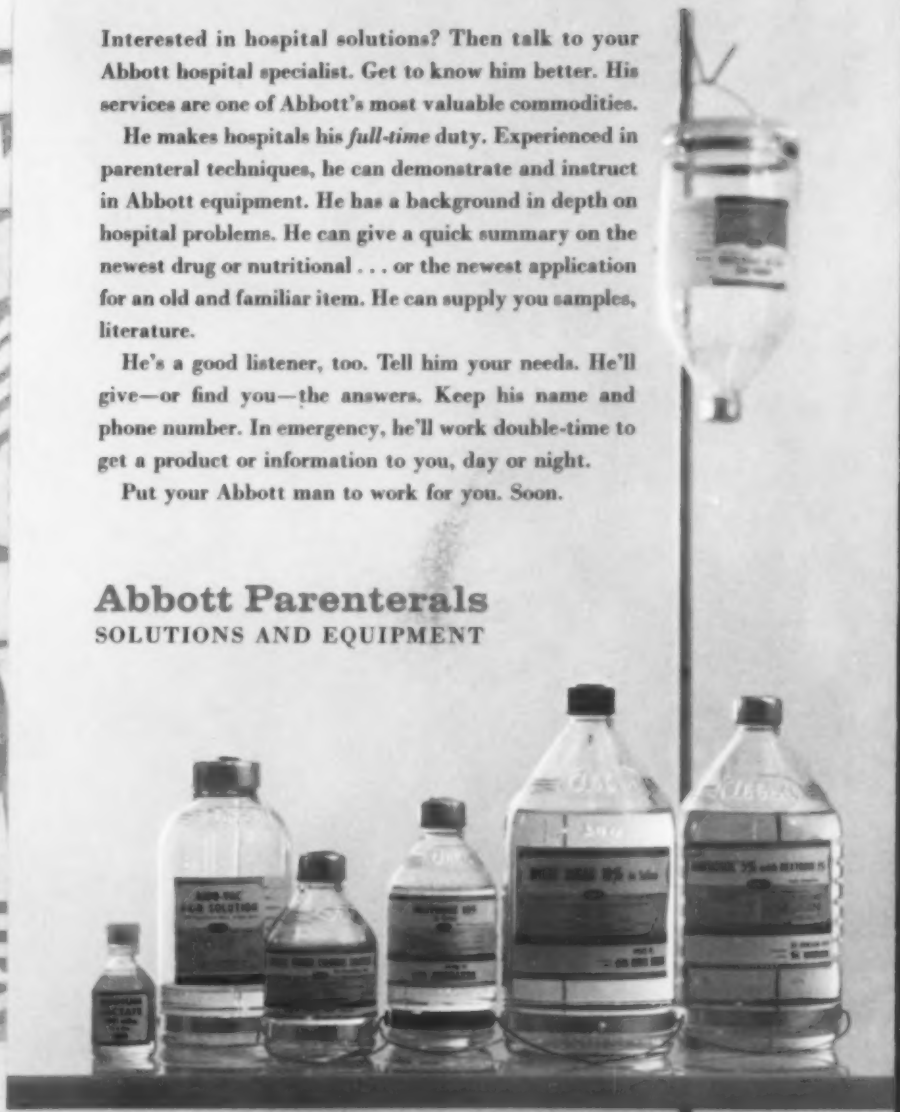
Reliability in Action

Interested in hospital solutions? Then talk to your Abbott hospital specialist. Get to know him better. His services are one of Abbott's most valuable commodities.

He makes hospitals his *full-time* duty. Experienced in parenteral techniques, he can demonstrate and instruct in Abbott equipment. He has a background in depth on hospital problems. He can give a quick summary on the newest drug or nutritional . . . or the newest application for an old and familiar item. He can supply you samples, literature.

He's a good listener, too. Tell him your needs. He'll give—or find you—the answers. Keep his name and phone number. In emergency, he'll work double-time to get a product or information to you, day or night.

Put your Abbott man to work for you. Soon.



Abbott Parenterals

SOLUTIONS AND EQUIPMENT

This Thomas Vroman painting, exemplifying reliability in action, is available on heavy 14½ x 19 paper without advertising, for framing. Write for "Stonewall Jackson," to Professional Services, Abbott Laboratories, North Chicago, Ill.

They Have Such Awful Manners in Hospitals

(*Continued From Page 97*)

proper perspective, is to start doing something for others. Everyone knows that the greatest human want is to be wanted. I might be getting beyond my depth now, but it could be that fairly healthy and sound patients could be encouraged to do more little services for other, more seriously handicapped patients. This theory presumes that a new patient is introduced around. It also presumes some tact on the part of the nurse, and approval of the attending physician. In my case I know I could have done some of the lifting and steadying a great deal more effectively than the nurses assigned to these chores. But, under the pseudo-professional code in effect in my hospital, my offer would have been declined. So I stayed in bed, cultivating a guilt complex.

8. All patients aren't acrobats. In my home I can and do have telephones at convenient places. But when I am hospitalized it is assumed I am an acrobat. Even though a patient may have a strip of painful stitches or be only partially out of the anesthetic, he is expected to stretch and crawl if he wants to answer his phone. A phone rings. First the patient, if he is in a four-bed room, decides whether it is his phone or the one across the room. In my case the tones were the same, though they needn't have been. Then the long, unsteady reach. You remember that you had put the phone at the edge of the bed table after the last call, but the aide had thoughtfully rearranged the table. Now the phone is blocked off by a box of candy, a glass half filled with water, and an ash tray. Fumbling, you shift things about, dropping the glass on the floor. Finally you are in a position to say, from an angle, "Hello." The caller naturally says immediately, "You sound tired. I'll let you go back to sleep." And by that time you are tired! Besides, you are leaning far out of the bed, you are off balance, and you have shifted weight onto your stitches.

PHONE COMPANY COULD FIX IT

Now you can't beat the phone companies for service and ingenuity. They could arrange a hookup with the cumbersome box out of the way and the handset at the edge of the bed or in some other convenient place where it wouldn't be competing for space with tissue box, cigarets, candy, flowers, drinking water. It would cost nothing to find out what could be done to avoid these communications crises.

9. Doctor, don't be afraid of the other patients. On my last hospital visit I was confirmed in one long-standing opinion: Doctors generally have a pleasant and reassuring bedside manner—*but only for their own patients.* I had plenty of time to observe the attitudes of four attending doctors, plus my two, whom I reluctantly have to include with the others. The doctor making his rounds enters the room, picks out his patient, and moves smartly across the floor directly to that bed, oblivious to any other sign of human life in the room. Why? Well, he probably has his reasons. He doesn't want to waste time in rambling conversations. He doesn't want to give the impression he's prying on another doctor's case. I am not suggesting that the doctor get involved in a long medical discussion with someone else's patient, which admittedly would be highly improper. I have known many doctors, and with few exceptions they are pleasant, warm-hearted individuals. I am merely suggesting that in the hospital room they act natural—not like goons. If the doctor would just smile and mumble in the direction of the other beds that would be something. But does he do it? None that I have encountered!

10. Not every patient is a robber at heart. It has been established that most people in this country are honest. They may try to beat the horses, but they seldom try to run out on their just obligations. The Internal Revenue Service operates on this principle, and it is an eminently successful collection agency.

HOSPITALS TRUST NO ONE

But hospitals? No siree. They are still living in the days when you watched the scales as the butcher weighed your meat, and when you took your six-shooter along when you went out to collect your accounts.

These are harsh charges, but I have two identical experiences, at two different hospitals, to back me up. I shall give details of the last one.

When I arrived to settle up at the cashier's window at the end of my last hospital stay, carrying my suitcase and a radio, and further burdened down with thoughts of how I could pay my unexpected medical bills, I was greeted by a cool young lady who announced, without any preliminaries:

"We haven't got all the information we need on your insurance, so you will have to pay the entire bill. Then when the insurance comes through we will endorse the check over to you."

Now, I have been working for the same organization for many years. Our family has used the same hospitalization insurance repeatedly in the past. I had produced my Blue Cross card on admittance five days previously. I have been a property owner and a taxpayer in the same area for many years. I am at least a stable citizen, if not a substantial one.

Yet this girl was telling me, in rote fashion, that I would have to pay the entire bill right then and there. I had no argument about the bill. Considering the services I had received it was fair, but it had reached quite a figure. Credit has never been a problem for me. I buy furniture, clothing and household appliances in a very simple way—by paying down whatever is convenient and paying the rest in 90 days without interest. That seems to satisfy the people who are taking the risk.

HE HAD PREPAID IT

Besides, I had *prepaid* most of this hospital bill, not over a few months but over the 20 years or more in which I have carried hospitalization insurance. The hospital had had five days to check up on my insurance. In that time they could have got word back from the moon. I had been on the floor above the business office all that time, but this was the first indication I had that something was wrong—as I stood in line at the cashier's window, holding up others who were trying to check out but who meanwhile were mopping up all the details of my situation.

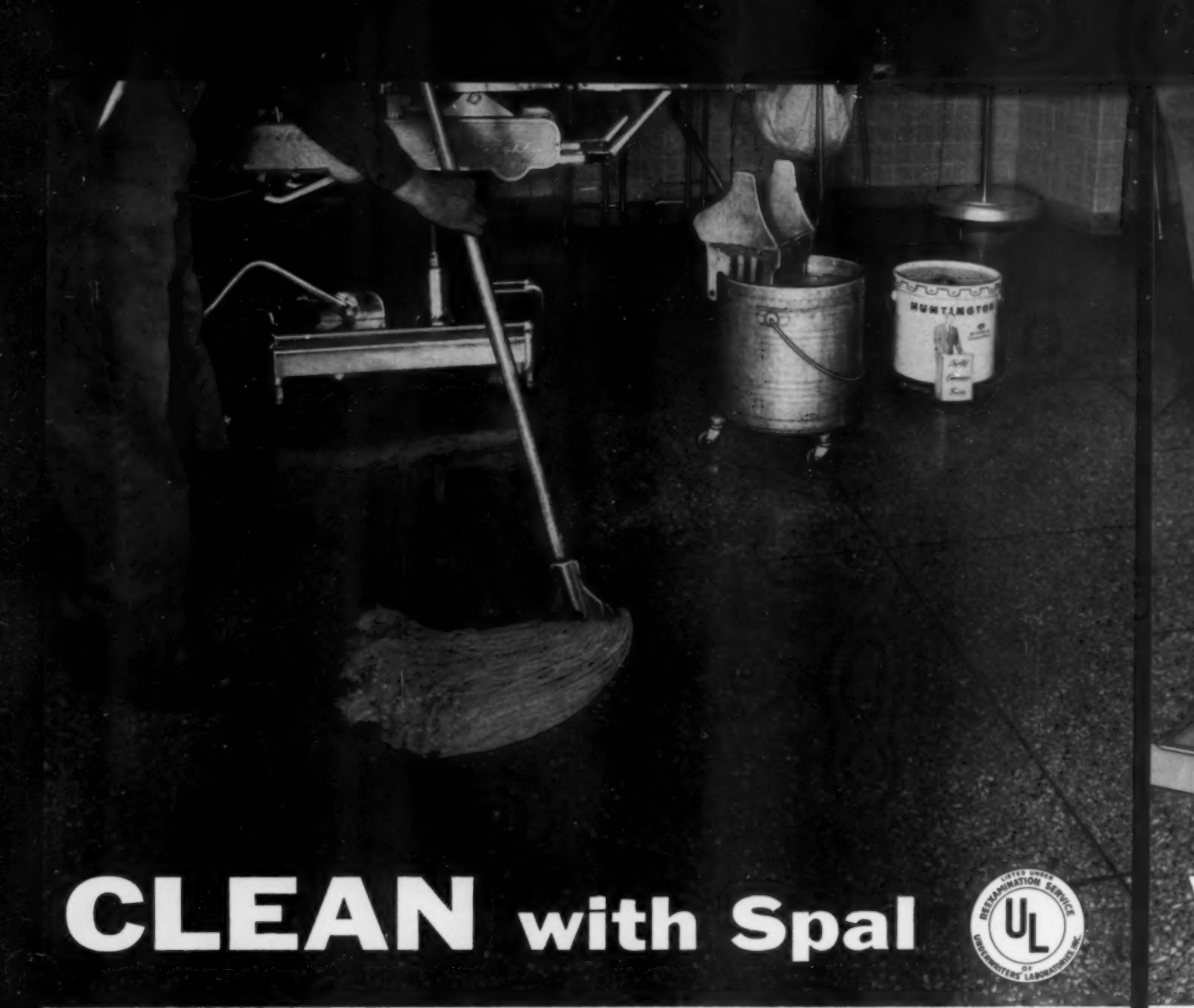
Naturally, I said I wouldn't pay it. Who would? "In that case," I was ordered, "you'll have to see Miss Blank in the office."

Miss Blank was not so cool. She was intelligent, understanding and reasonable. She was sure my Blue Cross arrangement would all be settled shortly, but in the meantime would I sign a note for the portion charged against Blue Cross? This I did readily, scribbling on the note, "Pending settlement of insurance." Whether this notation meant anything legally, I don't know, but it did make me feel I was putting up a defense.

With any large hospital, I expect these situations occur daily. But why should they? My hospital had had adequate time to get all the information needed, and if there were problems I could have been alerted before I stepped up to the cashier's window. That isn't the way to run a railroad.

Accepting that there was human failure somewhere along the line, at least the hospital could have handled the denouement less dramatically.

My condition was diagnosed accurately and promptly, and treatment was specific and effective. I am not mad at anyone.



CLEAN with Spal

TESTED UNDER "RE-EXAMINATION" SERVICE OF UNDERWRITERS' LABORATORIES INC. UL

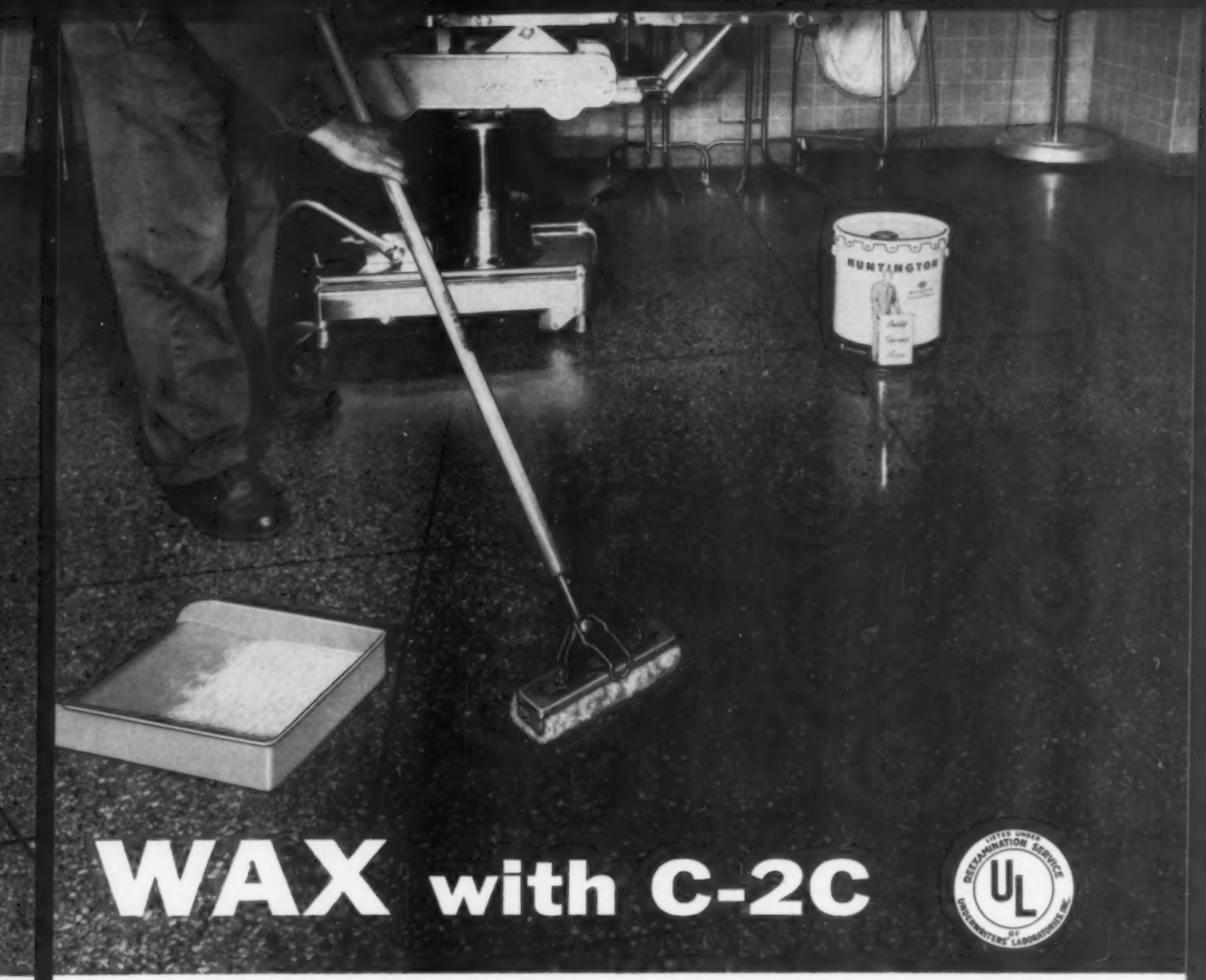
The only complete for conductive

Ask for the Man Behind the Drum

. . . your Huntington representative. His services are offered to you without charge.

All conductive floors should be tested regularly, using the National Fire Protection Association Test, as explained in the Huntington booklet "How to Maintain Conductive Floors." Write for your free copy.

HUNTINGTON . . . .



WAX with C-2C

maintenance program floors (AND LISTED BY UNDERWRITERS' LABORATORIES)

FOR GREATER SAFETY, BETTER SANITATION AND LASTING FLOOR PROTECTION

Now you can keep conductive floors cleaner, more sanitary and make them last longer without extra work, with Huntington's complete maintenance program for conductive floors.

Both Spal Concentrate Detergent and C-2C Conductive Wax are listed by Underwriters' Laboratories Re-examination Service as safe for electrically conductive floors. (C-2C is *the only conductive wax* listed.)

Spal is a heavy duty, synthetic, all-purpose detergent for conductive floors and any other surface throughout your hospital. Its cleaning ability has been proved far superior to other conductive floor cleaners.

C-2C is listed by Underwriters' for its anti-slip properties, freedom from danger of spontaneous combustion, and safe electrical properties.

See the Man Behind the Drum, your Huntington representative, for more details and write for free booklet, "How to Maintain Conductive Floors". . . Huntington Laboratories, Inc., Huntington, Indiana, Philadelphia 35, Pennsylvania, Toronto 2, Ontario.

. . . . . where research leads to better products

NEWS DIGEST

Pickets Ask Reinstatement of Pontiac Surgeon . . . Delay Rate Increase for New York Blue Cross Plan . . . Nonprofit Hospital Cannot Exclude Licensed Physician, Court Rules . . . Methodists Elect Victor B. Hann . . . Peel Heads Protestant Group

Pickets Ask Surgeon's Reinstatement at Pontiac; Medical Staff Commends Administrator in Suit

PONTIAC, MICH. — Petitioners last month picketed the Pontiac General Hospital here, calling for reinstatement of Dr. Neil H. Sullenberger, surgeon who was dropped from the medical staff and promptly sued the hospital and its trustees for $250,000.

When a petition reportedly including 841 signatures failed to produce action in Dr. Sullenberger's behalf by the city commission, owners of the hospital, one of the petitioners said the group would ask Michigan's Gov. G. Mennen Williams to intervene.

Meanwhile, city commissioners asked for a report from the hospital on Dr. Sullenberger's dismissal.

Separate investigations of the dispute were also under way by the State Board of Registration in Medicine and the county prosecutor's office.

Solid support of the hospital's stand in dismissing Dr. Sullenberger, and support for Administrator Flath, were indicated in a resolution passed unanimously at a meeting of the hospital's medical staff early in February.

The resolution said Dr. Sullenberger had "carried on a course of conduct over an extended period of such a nature as to demonstrate his disdain and utter contempt of (hospital) standards and principles."

The medical staff of the hospital expressed disapproval of Dr. Sullenberger's public statements and actions, "especially the unjustified attacks upon the person of Carl I. Flath, whose only rôle in the present litigation was that of agent of the board of trustees and the medical staff," the resolution continued.

"The medical staff commends the board of trustees for its forthright action in protecting the public interest by invoking long established, reasonable and necessary hospital rules and regulations which are characteristic of all accredited hospitals and are designed solely to control and promote high standards of professional practice," the staff said. "The medical staff commends Carl I. Flath for the courageous and exemplary manner in which he has effected the temporary suspension of Dr. Sullenberger on behalf of the board of trustees, and his handling of the events arising therefrom."

Petitioners in Dr. Sullenberger's behalf said he should be reinstated to the hospital staff "for the care and welfare of his patients."

Many of Dr. Sullenberger's patients need his care but are denied it because he is no longer allowed to practice in the hospital, the petition said. "We still have faith in our doctor but have lost confidence in Pontiac General Hospital because he was suspended," it added.

The Sullenberger suit charged that the sole authority for regulating the practice of physicians and surgeons in public hospitals is vested in the State Board of Registration in Medicine and that local hospital rules were therefore invalid.

Photograph courtesy "Pontiac Daily Press."

Pickets gather in front of Pontiac General Hospital, Pontiac, Mich., to ask the reinstatement of Dr. Neil H. Sullenberger.

New York Blue Cross Plan Rate Increase Is Delayed; Hike Asked in Other Areas

NEW YORK.—Action by the New York State Insurance Department on a proposed 40 per cent increase in Blue Cross subscription rates has been delayed pending the results of a month-to-month study of the organization's financial experience and continued use of its reserve funds to pay hospital bills, it was announced last month.

Request for the increase in rates was made late last year by Associated Hospital Service of New York, and was followed by public hearings by the state superintendent of insurance, Leffert Holz.

In his opinion, Mr. Holz said he recognized the need for higher subscription charges, and indicated that he would give immediate attention to a new application when it became apparent that the statutory reserve fund which is required by law would be impaired.

Mr. Holz said he would authorize temporary withdrawals from the reserve fund if required, to meet the plan's operational needs.

Charles Garside, chairman of the board and president of Associated Hospital Service of New York, called the situation "more critical every day." He said that during the next few months, Blue Cross payments are expected to average $1.25 for every $1 received from subscribers. Without a rate increase, it will be necessary to request authorization to use statutory reserve funds before June 30, Mr. Garside said.

The superintendent's decision to permit use of reserves set aside and maintained at a certain level by law is not a solution to the need for higher rates, Mr. Garside said. The Associated Hospital Service will have to submit a new application for increased rates almost immediately, he continued.

In New Jersey last month, Blue Cross asked the state department of banking and insurance to approve an over-all increase of 28.9 per cent in its rates.

NEW A.C.M.I. STERILE PACKAGED

INFLATABLE CATHETERS

- Save nurses' time
- Eliminate autoclaving expense
- Reduce patient-care costs

Double protection

...double safety...

ready for instant use

The new A.C.M.I. Sterile Packaged Premium Catheter is double-protected by double packaging, for *assured* sterility. Even should the durable outer non-peelable package be torn or cut by unduly rough handling, the resilient inner peelable package still protects the sterile catheter from contamination.

Sterilization is achieved under rigidly controlled conditions; and is checked by thorough bacteriological testing before each lot is released. These catheters meet U.S.P. sterility standards and government specifications.

FREDERICK J. WALLACE, *President*

American Cystoscope Makers, Inc.

PELHAM MANOR, NEW YORK

Nonprofit Hospital Without Right to Exclude Licensed Physician, Michigan Court Decides

ALLEGAN, MICH. — Bylaws giving trustees of a nonprofit hospital unqualified power to grant or deny the right of a duly licensed physician to practice in the institution are "void and of no effect" in the state of Michigan, Circuit Judge Raymond L. Smith ruled here last month.

The court held that Dr. William A. Koprasch was entitled to practice in the Allegan Health Center, "subject to the bylaws governing all members of the staff."

Dr. Koprasch had filed a complaint seeking an injunction restraining the hospital from excluding him, when his application for staff membership was denied.

In his opinion, Judge Smith noted that plaintiff's license to practice had been revoked in 1943 when he pleaded *nolo contendere* on a charge of sending narcotics through the mail. The license was restored in 1948 by the State Board of Registration in Medicine, and the hospital claimed the board was without power to restore the license and therefore questioned plaintiff's present license.

Denying that the board of registration was without jurisdiction to restore the license, the court held further:

"This court finds that the action of the Board of Registration in Medicine in 1943 and 1948 is not a proper ground for refusal of plaintiff's application to practice medicine and surgery in defendant hospital, and further that defendants are without authority to base any such denial upon any of the events or activities of the plaintiff before the board of registration at the time of the suspension of plaintiff's license.

"Insofar as the bylaws and regulations of the Allegan Health Center purport to grant to its board of trustees the unqualified power to grant or deny the right of a duly licensed medical doctor in the State of Michigan to practice in its institution they are void and of no effect. . . . Accordingly the court finds that the refusal of plaintiff's application was without legal effect and further finds that plaintiff is entitled to practice in the Allegan Health Center subject to the bylaws governing all members of the staff."

Referring to the Michigan Supreme Court decision in the case of Albert v. Gogebic County Hospital, the court said, "The Allegan Health Center is not a private institution with such proprietary rights that would allow it to exclude patient and doctor because of such rights; nor is it a public institution in the sense that it is governed by a municipal corporation. . . . The Allegan Health Center is a nonprofit, charitable corporation organized to meet the medical needs of the community which it serves. It is sustained through the joint contributions of the federal government, private grant, public subscription, municipal favor, and fees charged for services."

The Albert case is authority for the proposition that a license to practice medicine in Michigan is a license to practice in the public hospitals of the state unless there is express authority to the contrary, the court held. "It would appear that justice and reason should dictate the same result in quasi-public hospitals such as we have before us where the institution serves a public need and not a private right," the opinion continued. "Especially is this true where we are dealing with the relationship of doctor and patient in which the needs of the patient are paramount.

"If we commence with the need of the patient for the facilities of a hospital and give full weight to the

NECESSARY NOW...

in all *fully-equipped hospitals!*

almost indispensable for *polio* treatment — very desirable for *vascular* and *neuropathic* cases —

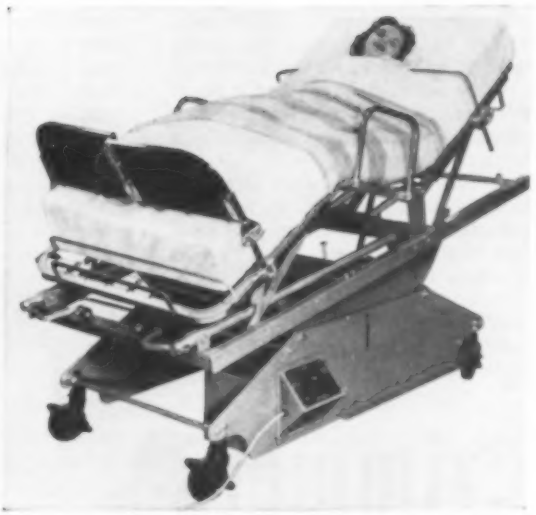


Photo No. 1—Inhalation Completed. Photo No. 2—Exhalation Started. Photo No. 3—Exhalation Completed. Respiratory cycle is from Photo No. 1 to Photo No. 3 and back to Photo No. 1. Speed and angle of oscillation is regulated by controls on instrument attached to base of bed.

McKesson Respiraid Rocking Beds

Polio—Almost every leading institution in the treatment of poliomyelitis is now equipped with McKesson Respiraids—by far the preferred method of weaning patients away from tank-type respirators.

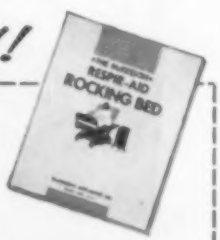
Vascular—Natural stimulation from Bed's rocking motion especially beneficial to many types of such cases. Respiraids now widely used for this purpose.

Neuropathic—Whenever neuropathic disorders affect respiration, McKesson Respiraid Rocking Beds have been successfully used. Use for this purpose is increasing rapidly.

Because McKesson Respiraids are used in *all three of these ways*, most leading hospitals have found this equipment necessary for proper treatment of some of their patients.

So, *just to be fully informed and to be sure your hospital is properly equipped*, ask us by note, telegram or phone-call for our McKesson Respiraid Rocking Bed Brochure—or

Clip Coupon and Mail TODAY!



McKesson Appliance Co.
Toledo 10, Ohio

Please send your McKesson RESPIRAID Rocking Bed Brochure and information on how other Hospitals are using this Product.

(Name)

(Number—Street)

(City—Zone—State)

McKesson
RESPIRAID
ROCKING BEDS

acknowledged right of a patient to be treated by the doctor of his choice, there is little room for argument that a doctor must have extra qualifications in order to follow his patient into such an institution as the Allegan Health Center."

It does not follow from denial of the hospital's right to exclude the plaintiff physician from hospital practice that the hospital has no power at all to regulate practice in the institution, the court stated. "Such a result would lead to chaos and would not be in the best interests of the constituency to be served," Judge Smith acknowledged. "But regulations to be valid must not be unreasonable, arbitrary, capricious, or discriminatory. To escape this taint any denial of the right to practice should be accompanied by specifications apprising the applicant of the reasons for the refusal. Anything short of this requirement would be a failure of due process as applied to a public or quasi-public hospital.

"This record is devoid of any such specifications," the court concluded. "Indeed, when we cast aside the claimed revocation of license and give the conviction for practicing medicine while the license was revoked the weight it deserves (none) we have nothing left but the conclusion that plaintiff is *persona non grata*. That is not a sufficient reason for refusal to allow plaintiff to practice in defendant hospital. It is significant that defendants cannot come up with any case of malpractice, unprofessional conduct (except the matter already acted upon by the board of registration), or lack of ability experienced by the community after a quarter of a century of practice by the plaintiff."

Stranded Motorists Seek Shelter in Hospital as Snow Storm Blocks Roads

MICHIGAN CITY, IND.—Hospitals in this area served as havens for motorists last month after they were stranded in a freak storm that dumped 32 inches of snow and piled up 12 foot drifts in less than two days.

Some 20 occupants of stalled cars were given shelter at Dr. Norman Beatty Memorial Hospital, a state institution for the mentally ill in near-by Westville. Members of the hospital staff who were on duty when the storm struck Saturday, February 15, stayed on duty for several days, since snow clogged streets made it impossible for other employes to reach the hospital.

At Doctors Hospital here, staff members had to battle snow drifts on foot to reach the hospital, and many remained overnight, Administrator Mildred Goers reported. Four babies were born in the hospital at the height of the storm. Three of the mothers were taken to the hospital in jeeps, and the fourth in a fire department pumper.

A power plow was used to clear the way for an ambulance to remove a small child to the hospital for emergency treatment.

New York Council Studies City Hospital Situation

NEW YORK.—The number of general care beds now operated by member hospitals of the United Hospital Fund is consistent with community needs, but these hospitals should assume further responsibilities in the areas of psychiatric and long-term care, it was reported last month.

This was among preliminary conclusions reached by the Hospital Council of Greater New York in its exhaustive study of hospital plants of member hospitals of the United Hospital Fund. The council also is studying funds needed to correct deficiencies in the plants and to enable the hospitals to meet their community responsibilities.

Lack of Ward Patients Alarms Medical Educators

(*Continued From Page* 50)

the A.M.A. and the Advisory Board for Medical Specialties, Dr. David B. Allman, A.M.A. president, warned hospitals that there are going to be teeth in the new program of the Educational Council for Foreign Medical Graduates. The American Hospital Association is considering the advisability of not listing hospitals employing foreign medical graduates not certified by the Council, he reported. In addition, the Council on Medical Education and Hospitals will consider withdrawing approval of internships and residency training programs in hospitals accepting noncertified foreign medical graduates. The state department may grant visas for U.S. study only to certified graduates, and the specialty boards will require certification for approval of training, Dr. Allman said.

Effective Jan. 1, 1960, the Council on Medical Education and Hospitals and the Association of American Medical Colleges will withdraw their present listings of foreign medical schools, it was explained, because of inability to obtain adequate information about current programs in the schools. Instead, the Council and the Association will recommend that hospitals, licensing boards, specialty boards and other agencies consider that certification by the Educational Council for Foreign Medical Graduates is evidence that the recipient has medical knowledge comparable to that of graduates of U.S. and Canadian medical schools.

A trial period to adjust the Council's program to the needs of hospitals would be necessary, Dr. Allman acknowledged. "Hospitals with outstanding educational programs, which because of unfortunate prior experience have closed their doors to foreign medical visitors, will now be encouraged again to accept foreign medical graduates," he concluded.

In workshop sessions, physicians and hospital administrators attending the Congress discussed population, economic and social trends affecting the need for physicians, medical facilities, and medical education programs. Population growth and movement will continue to be in outlying areas rather than urban centers, the workshop groups agreed. The underprivileged class is disappearing from our society, it was emphasized; people have more money and thus need more medical service, which in turn requires more physicians, paramedical workers and hospitals.

Divergent views were expressed, however, on the need for more physicians. While many felt medical schools will have to increase their output by as much as 2000 graduates a year to keep up with the growing population, others pointed out that, with all the staff and facilities now at his disposal, the physician can care for twice as many patients as was possible 25 years ago, and this trend is likely to continue, thus cutting down the demand for larger numbers of physicians.

A workshop session on changing characteristics of society emphasized the obligation of the public to understand doctors and use their services more effectively. The workshop session on changing dimensions of medical knowledge addressed itself to the problem of crowded medical curricula and reported that the only solution lies in abandoning the concept that all physicians should be able to cope with all kinds of medical problems.

The workshop report suggested that medical schools would have to "eliminate significant masses of knowledge required now of all medical students," and settle instead for a certain amount of ignorance on the part of graduates. The problem would then remain one of determining "how much ignorance, and in what fields," the report concluded.

WHEN YOU TREAT INFECTIONS IN PATIENTS SUCH AS THESE

- debilitated
- elderly
- diabetics
- infants, especially prematures
- those on corticoids
- those who developed moniliasis on previous broad-spectrum therapy
- those on prolonged and/or high antibiotic dosage
- women—especially if pregnant or diabetic

the best broad-spectrum antibiotic to use is

MYSTECLIN-V

Squibb Tetracycline Phosphate Complex (Sumycin) and Nystatin (Mycostatin) — Sumycin plus Mycostatin

for practical purposes, Mysteclin-V is sodium-free

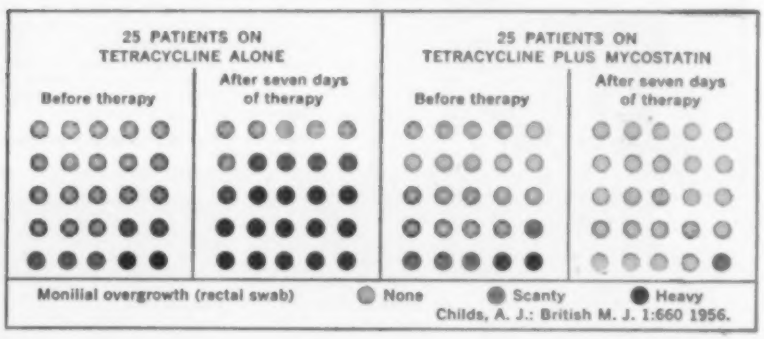
for "built-in" safety, Mysteclin-V combines:

1. Tetracycline phosphate complex (Sumycin) for superior initial tetracycline blood levels, assuring fast transport of adequate tetracycline to the infection site.

2. Mycostatin—the first safe antifungal antibiotic—for its specific antimonilial activity. Mycostatin protects many patients (see above) who are particularly prone to monilial complications when on broad-spectrum therapy.

Capsules (250 mg./250,000 u.), bottles of 16 and 100. *Half-Strength Capsules* (125 mg./125,000 u.), bottles of 16 and 100. *Suspension* (125 mg./125,000 u.), 2 oz. bottles. *Pediatric Drops* (100 mg./100,000 u.), 10 cc. dropper bottles.

MYSTECLIN-V PREVENTS MONILIAL OVERGROWTH



Childs, A. J.: British M. J. 1:660 1956.

SQUIBB

Squibb Quality—the Priceless Ingredient

A.H.A. Midyear Delegates Hear Project Reports

(*Continued From Page* 49)

members of the A.H.A. also will be given the service without charge.

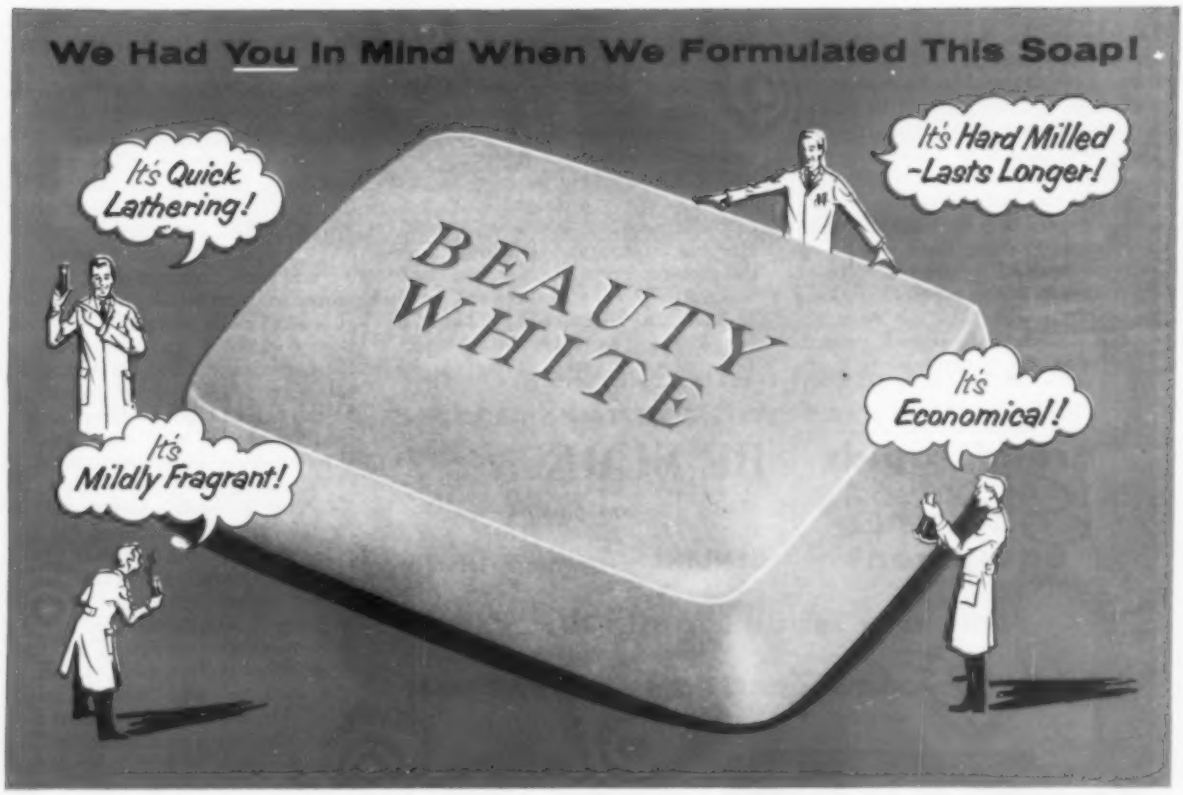
In his report on the two-year study of the operation of hospital planning and license laws, Dr. Alan E. Treloar, director of the hospital research and educational trust, stated that the research group will recommend that each state should accept the primary responsibility for establishing a balance of various types of facilities in the field (acute general hospitals, nursing homes, rehabilitation centers); for appropriate geographic distribution of facilities; for setting standards of construction, and for standards of operation through licensing laws. The study group regretted, Dr. Treloar said, that there is "some tendency to separate the nursing home problem from hospitals." Nursing homes, the committee believes, are a part of the whole health problem and should not be set apart. All planning and licensing functions, the report urges, should be unified in one agency in the state —preferably within or related to the state health department—and not be dispersed among many agencies. Hospitals and doctors have their differences, but they also have interlocking responsibilities, Dr. David B. Allman, president of the American Medical Association, told the luncheon session of the conference. Flanked by a sizable contingent of A.M.A. dignitaries, Dr. Allman urged that the two groups should get together to solve their common problems "before the troubles start."

Right now, a most urgent problem is chronic illness, he stated. "Rising costs of chronic illness are an increasing challenge. It is our common responsibility to devise some means of finding a way patients or community agencies can pay the costs. The problem is not strictly one of medical or hospital economics. It has to be faced by the community. The obligation must be assumed by all the people."

Two methods of meeting the problem urged by Dr. Allman are an intensified program of practical nurse education and increasing the number of nursing and convalescent homes. Costs of the practical nurse education program should not be borne by the hospitals or sick patients, Dr. Allman asserted. Education is a community problem and should be conducted at the state and local levels. He directed a low bow in the direction of the state of Indiana which, he reported, is the only one of the 48 states that has not applied for federal aid.

Granting that many nursing homes now give substandard care, Dr. Allman nevertheless believes that they have an essential rôle in providing care for long-term patients and that "time and standardization of qualifications" will correct their deficiencies. He would like to see nursing homes set up by hospitals to be operated as separate institutions but governed by the hospitals' standards.

Another common problem of hospitals and doctors is what to do about graduates of foreign medical schools. What the American Medical Association wants done was reported to the midyear conference by Dr. J. Murray Kinsman of Louisville, Ky., president of the Educational Council for Foreign Medical Graduates. (See also page 50.) The educational council, headed by Dr. Dean Smiley, has been set up to accredit individual graduates on the basis of an evaluation of the applicant's credentials, an examination including 800 questions on the basic sciences, and certification of applicants who pass the examination to hospitals and state boards. Information on the program has been widely distributed and the first examination (to be given only in the United States) is scheduled for March 28. A second one will be administered both



YES! *Beauty White*

IS MADE TO ORDER FOR HOSPITAL USE!

We asked hospitals—just like yours—what features you would suggest for the *perfect* toilet soap. You said you wanted a quality soap—a soap that would give abundant lather in all types of water. You also specified that it be mildly fragrant and hard milled to *last longer*. And here it is—Colgate's BEAUTY WHITE! The soap specially formulated with *you* in mind. So make your next order BEAUTY WHITE. Patients will appreciate it—you'll *save money!*

For Your Convenience . . . two sizes packed unwrapped.

Also one size available wrapped.

And For Your Private Pavilion—
Mild and Gentle Palmolive Soap in its famous green wrapper. Quick lathering, meets highest hospital standards for purity, mild and easy on the skin. Write for sizes and prices.

Colgate-Palmolive Company

300 PARK AVENUE, NEW YORK 22, N. Y.
ATLANTA 5, GA. • CHICAGO 11, ILL.
KANSAS CITY 5, KANS. • BERKELEY 10, CALIF.

FREE! Latest Edition Handy Soap and Synthetic Detergent Buying Guide. Tells you the right product for every purpose. Ask your C.P. representative for a copy, or write to our Associated Products Dept.

in this country and abroad in September. As the program gets under way, examination centers will be established according to the load of applicants. The council expects to charge $50 to each successful applicant (if they don't pass they don't pay) and also expects a "donation" of $75 from hospitals for each candidate a hospital accepts. It is the A.M.A.'s hope that before too long there will be no foreign medical graduates (except those already in this country) working in hospitals who have not been accepted by the educational council. The midwinter conference is traditionally devoted to a discussion of "significant developments" in the hospital field and the meeting this year took official notice that one of the most significant is the development of micrococcal infections in a growing number of hospitals. Reporting for the A.H.A. Committee on Hospital Infections, Dr. Dean A. Clark, general director, Massachusetts General Hospital, Boston, stated candidly that the problem exists "in most, if not all hospitals. If a hospital doesn't seem to have any infection, it probably is because it just hasn't been discovered." There are still many things to be learned about the causes of outbreaks, Dr. Clark stated, but it is known that some things make people more susceptible. Among them are prolonged stay in the hospital, treatment with steroid hormones, and the number of contacts with carriers. "The personal carrier is probably the key to the spread of infection," Dr. Clark added.

The A.H.A. committee urges that every hospital establish a committee on infections, composed of doctors, nurses and bacteriologists, and that all infections be reported to the committee "without fear or favor," Dr. Clark continued, "and the A.H.A. will recommend to the Joint Commission on the Accreditation of Hospitals that establishment of such committees be a requirement for accreditation."

Following Dr. Clark's report, Dr. Kenneth Babcock, director of the Joint Commission, informed the delegates that the commission is already one jump ahead of them. "In its March *Bulletin*, the Joint Commission is going to recommend that hospitals have infections committees," he stated. "And either in September or October, the standard will become mandatory." Dr. Babcock added: "But never mind what the Joint Commission does. Some hospitals have 30 to 40 per cent infection rates, so get those committees started right now."

In case any nurses want to know what the American Hospital Association has done for them lately, Dr. Clark (pinch-hitting for Dr. T. Stewart Hamilton of Hartford, Conn.) was ready with the answers. Reviewing the activities of the A.H.A. committee on nursing, he pointed out that the association has (1) made efforts to establish teacher-training programs; (2) supported the National Commission on Nursing; (3) collaborated with the Public Health Service on nursing studies; (4) supported the passage of the nurse training act; (5) supported the establishment of practical nurse schools; (6) worked with the American Nurses' Association on its economic security program; (7) continued its attempts to find better methods of appraising costs of schools of nursing; (8) continued its nursing institutes, and (9) collaborated with the National League for Nursing on the accreditation program.

Of the 953 diploma schools of nursing, Dr. Clark said in concluding his report, 364 are fully accredited and 358 are provisionally accredited.

The aged and chronically ill came back into the spotlight at the Saturday morning session of the conference. Dr. Albert W. Snoke, past president of the A.H.A., reviewed the studies and negotiations leading to the A.H.A.'s statement of policy on the Forand Bill issued in January and

stated that while the A.H.A. recognizes the existence of a problem in the provision of health facilities and service for the aged, the association sees the problem as formidable but not urgent enough now to justify the introduction of a new element in federal social security that can be expected to continue indefinitely and might have unfavorable results. However, an informal poll of the delegates at the midwinter meetings revealed that, although they do not favor the Forand Bill, a majority believes that social security is the best mechanism for providing health care for the aged.

A.C.H.A. Stresses Management Problems at Silver Anniversary Congress in Chicago

(*Continued From Page* 50)

30 times the ground area needed for the first building and that, before one single building is put up, there should be a master plan showing how all the space will be used.

At the conclusion of the discussion on policies that would help in "maintaining disciplinary balance," Moderator Thomas P. Langdon, administrator of Hahnemann Hospital, San Francisco, summed up by stating that many of those participating flatly opposed written policies. Quite a few held out for the freedom of the administrator to manipulate the work situation without regulations. Indeed, it was held, effective policies are only as good as the example and leadership given them by the administrator. Discipline is a set of regulations for total behavior, not solely for punishment, noted Dr. Roger B. Nelson, associate director of University Hospital, Ann Arbor, Mich., supporting a panel theme that personnel policies must involve more than "thou shalt not's."

The laboratory worker who is concerned solely with the quality of the test he is performing and who considers everything else unimportant is a professional, the panel on the "professional employe and the administrator" determined, wisely sidestepping the search for a more exact definition that threatened to get the session diverted into a bypass before its journey had scarcely begun. It is the administrator's job to discipline this talent and integrate it into the overall hospital program, it was concluded.

Personnel evaluations will encourage promotion from within the hospital, will point up weaknesses in the training program, and will spotlight weaknesses in supervision, the panel on "evaluating personnel potential" postulated. Agreeing that some factors in an evaluation can be measured quantitatively and others cannot, the panel urged the administrator not to be on the defensive about the latter. Presuming that he has some judgment, he has every right to use it, the panel members concluded. They agreed, however, that mutual rating systems are better than rating systems involving only the supervisor's opinion.

One of the "basic psychological factors in communication" is that people are not interested in being communicated to, the panel on this subject observed. Frank H. Magoffin, business manager of Oakville Memorial Sanatorium, Memphis, Tenn., said that he had varying success, even when employes were required to initial memorandums put on the bulletin boards. One suggestion was that the employe be given only the why's and wherefore's of decisions that involve him, without trying to explain policies with which he is not concerned. Another panelist urged the new administrator to introduce himself to his supervisors by visiting their offices rather than summoning them to his.

Facing the discouragingly common situation typified by an experiment cited in which a notice of a meeting had to be repeated 10 times before every member of a test group was able to recall the essential details, the panel on "eliminating roadblocks to understanding" decided that semantics was the answer. Semantics was defined as not only use of words and phrasing but also such things as tone, facial expression, gestures and other characteristics that give meaning to words. It was also noted that failure to give professional groups background on a decision may create a resentment to the decision.

Maintaining a neat balance between democracy and autocracy, a juggling act at best, is the dilemma posed by committees, the second day panel on that subject concluded. One administrator forcefully stated that, in his hospital, only committees of the board of directors have authority to act — all others are advisory in capacity.

The good administrator will be emotionally mature enough to admit his mistakes to himself and learn from them, the panel on "failures offer clues to success" decided. Just how far he can go on this tack before he begins to lose confidence in himself was another question. Summarizing, William M. McCoy, manager of the V.A. hospital at Hines, Ill., stated that the administrator must review constantly evidence of success or failure, know himself, and strive for the virtues of honesty, integrity and impartiality. Evidence of success or

NEW

STYLEX™

expendable hypodermic syringe

HOSPITAL PROVEN

SAFER
guaranteed sterility · nonpyrogenic · reduces danger of cross-infection.

MORE CONVENIENT
saves time · ends cleaning, sterilization, and needle sharpening.

MORE EFFICIENT
significant increase in over-all efficiency reported by current hospital users.

PHARMASEAL LABORATORIES
affiliate of DON BAXTER, INC.
GLENDALE 1, CALIFORNIA

PHARMASEAL®

®Trade-mark

failure can be gleaned from opinions of the administrator's peers, personnel, patients, supervisors and public.

Communication is the key word in considering "the administrator's rôle in setting and maintaining standards," this panel decided, after acknowledging that the physician is largely responsible for medical standards.

Automatic machinery regulated by automatic rather than human control constitutes automation, Malcolm P. Ferguson, president of the Bendix Aviation Corporation, told the Monday morning general assembly of the college.

As such, it is an evolutionary technological improvement, a logical next step in Henry Ford's line production concept, rather than a revolutionary improvement, he stated.

Automation owes so much to electronics that it might better be called electromation, Mr. Ferguson added. He said the possibilities of automation are controlled by four factors: the ability of man to dream and devise the process and machinery; the willingness of capital to make the high initial investment; the availability of skilled manpower needed to design, build and operate it, and the acceptance of the process by the public, particularly labor unions.

In this regard, Mr. Ferguson advanced the thesis that automation will be responsible, as was the production line, for labor displacement, not unemployment.

Studies of the decision making process and advances in scientific management generally, which have been helpful in understanding the reasoning of repetitive, day-to-day decisions, will be of real assistance to the administrator in making executive, precedentless decisions within 10 years, Prof. Herbert A. Simon told the Monday afternoon general assembly.

Defining the administrative task as the creative process of anticipating and preparing for innovations and unique situations, the speaker said that the administrator must create the alternatives.

"He must construct courses of action not in the repertoire," Prof. Simon said, contrasted with the situation in day-to-day decisions where the administrator draws on his judgment to find an application of well tested remedies. "If his judgment is sound, the solution can be termed wisdom," he added.

The professor cited several instances of scientific studies involving computors to support his thesis that help is on the way for the beleaguered administrator.

OPERATIONS RESEARCH DEFINED

Operations research, an exhaustive investigation of a system that serves some function or purpose in order to understand how it works and how it can be controlled or improved, was the topic of T. E. Caywood's speech at the Tuesday morning general assembly.

One example discussed by Mr. Caywood involved the questions that might be asked by an airline proposing to set up a ticket sales system. The answer to such questions as how many telephones, clerks, offices, check-in counters and gates will be required to adequately serve the anticipated demand are all problems of operations research.

The "C" rations of World War II were the result of operations research into the problem of providing paratroopers with a well balanced diet of minimum weight.

The application of strategy to administrative action becomes vital when we recognize the "colossal destructivity of a single blunder," Norman H. Martin, professor of industrial relations at the University of Chicago, told the final general assembly of the congress.

In evolving a strategy which he

defined variously as manipulating people to reach an end, planning the use of energy, the process of creating good situations, the process that enables the administrator to be at the strategic point at the right time, and a plan of action based on an assessment of resources, Prof. Martin said that a good intelligence system was imperative.

Such an intelligence system should consider:

1. Formal information, information that goes through channels.
2. Grapevine information, a knowledge of an ability to use cliques.
3. Information on personalities, to predict responses of individuals to particular circumstances.
4. Information gained from trial balloons, giving an indication of the strength of a given position.
5. Information gained from buffering, *i.e.* discussions of the proposed course of action with key personnel.

Information so gained must be evaluated for truth, meaning and its consistency to previous knowledge. Patterns must be sought and inferences and interpretations made.

MUST BE FLEXIBLE

Prof. Martin cautioned against inflexibility. He urged that the administrator operate in an unstructured situation so that quick decisions can be made, and cited one manager who recommended that decisions be kept off paper since they then become policy.

The banquet speaker of the congress was Sen. Paul H. Douglas of Illinois who traced the history of several medical advances that aroused opposition in their time and urged his listeners to strive in the same spirit.

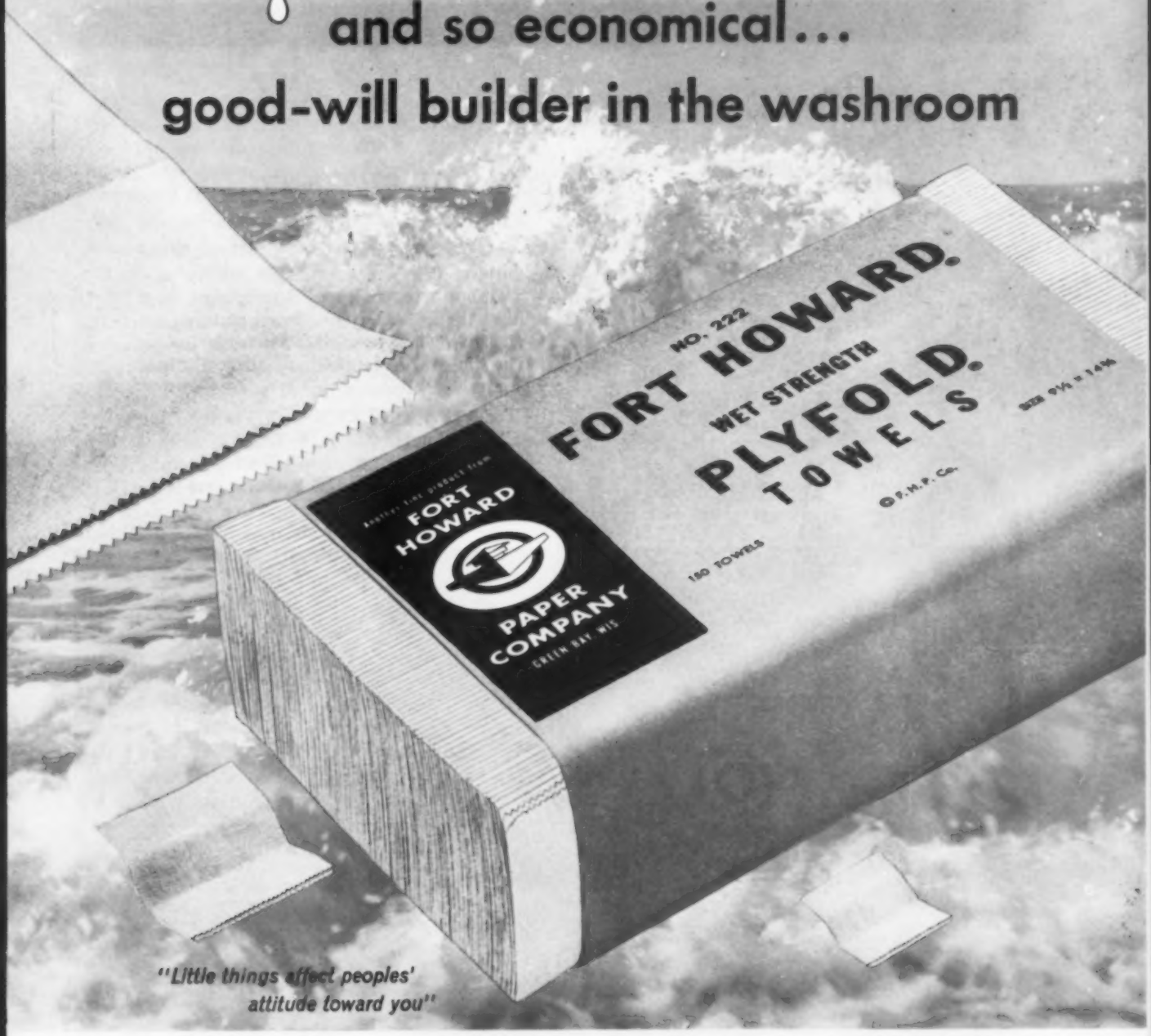
Prof. Simon was given the administrator's award by the college for his book "Administrative Behavior." A special committee selected it as a significant contribution to the science of administration.

"Principles of Administration," an article by Wallace S. Sayre of Columbia University, was chosen by a special article award committee as one of the most outstanding articles on the administrative process written in 1956.

Although the Congress on Administration was originally planned as a one-shot special meeting to celebrate the A.C.H.A.'s 25 years of existence, the interest shown by members led the board of regents to plan another one for next year—date as yet unknown. And it seems probable, according to A.C.H.A. officials, that the congress will become an annual affair. The convocation and business sessions will continue to be held in conjunction with the American Hospital Association conventions.

Absorbent...

and so economical...
good-will builder in the washroom



"Little things affect peoples' attitude toward you"

Fort Howard Paper Company

Green Bay, Wisconsin

America's most complete line of paper towels, tissues and napkins

of the hospital team!

50% or more. They are the only surgical sutures with individually formulated solutions for each size, assuring maximum pliability, resistance to fraying and controlled absorption.

Ohio offers a *comprehensive selection* of other suture materials as well. These include cotton, silk, nylon and stainless steel wire sutures.

Vastly improved methods for packaging sutures have also been developed by Ohio Chemical. The Dispenso-reel, for example, provides a new ease in handling sutures during surgery. It saves time, eliminates all kinking and tangling and provides a rapid and neat dispensing action.

Ohio's new sterile plastic packet for suture materials does away with the danger and mess of broken glass in the operating room. It meets exacting specifications of absolute sterility and safety.

Twenty-seven Ohio Chemical Branches offer a nationwide service . . . from the manufacturer directly to the user with *savings in suture costs passed on to the hospital.*

May we outline how your hospital can reduce suture costs — without loss of quality. Please write Dept. MH-3 for more details.

OHIO PRODUCTS

MEDICAL GASES • THERAPY OXYGEN
CENTRAL PIPELINE SYSTEMS
ANESTHESIA AND ANALGESIA APPARATUS
OXYGEN THERAPY AND RESUSCITATION EQUIPMENT
STERIL-BRITE FURNITURE • SURGICAL SUTURES AND NEEDLES
STILLE SURGICAL INSTRUMENTS

OTHER OHIO SUTURE MATERIALS

SILK AND COTTON DRY-PACK SUTURES

Ohio silk and cotton sterile dry-pack sutures are size-colored for quick identification in the operating room. Size 4/0 is pink, size 3/0 is blue and size 00 is white. Pre-cut 18", 24" and 30" strands are available.

BRAIDED SILK AND TWISTED COTTON SUTURES

Ohio braided silk and twisted cotton unsterilized sutures are available in a wide variety of sizes and lengths. These include 18" and 24" lengths, 25- and 100-yard spools. Size colors aid identification. Size 4/0 is pink, 3/0 is blue, and size 00 is white.

The cotton is of strong, long staple Egyptian fibers, smooth, uniform in diameter.

NEW CATALOG AVAILABLE

Indexed both by type of suture material and surgical use, this catalog contains full information on Ohio Chemical's entire line of sutures and needles. For your copy, please write Dept. MH-3 requesting Form 4708.

OHIO "Service is Ohio Chemical's Most Important Commodity"

Ohio Chemical

OHIO CHEMICAL & SURGICAL EQUIPMENT CO.
MADISON 10, WISCONSIN

Ohio Chemical Pacific Company, Berkeley 10, Calif.
Ohio Chemical Canada Limited, Toronto 2
Airco Company International, New York 17
Cia. Cubana de Oxigeno, Havana
(All Divisions or Subsidiaries of
Air Reduction Company, Incorporated)

At the frontiers of progress you'll find **An Air Reduction Product** . . . **Ohio:** Medical Gases and hospital equipment • **Airco:** Industrial gases, welding and cutting equipment, and acetylenic chemicals • **Puroco:** Carbon dioxide, liquid, solid ("Dry-ice") • **National Carbide:** Pipeline acetylene and calcium carbide • **Caltex Chemical:** Polyvinyl acetates, alcohols and other resins. AIRCO

Proportion of Nation's Resources Needed for Hospitals to Rise, Ray Brown Says

CHICAGO.—The proportion of community resources that must go into hospitals will continue to increase, Ray Brown, superintendent of the University of Chicago clinics, told a meeting of the Southwide Baptist Hospital Association here last month in conjunction with the American Protestant Hospital Association.

And, because prepayment will become almost universal, Mr. Brown said, it is the well person through whose eyes hospitals will be visualized. "It is the total bill translated into average payments per month we must worry about, not the sick person's hospital bill," he said.

The resources the community must provide will increase for many reasons, Mr. Brown pointed out. First, the tremendous increase in population will mean, assuming that the growth rate stays constant, that 70,000 more general hospital beds will be needed by 1975, an increase of 29 per cent over 1957.

For every baby born, for every new resident who moves into a town, that community will need $100 for additional hospital facilities, at present construction costs, Mr. Brown said.

Then, the changing character of the population will add to the total cost. There are more babies born today, 97 per cent of them in hospitals, and doctors are saving a greater percentage of them. There is increased longevity, and older people use the hospital more often, and stay longer, he pointed out. Statistics of the Metropolitan Life Insurance Company show that in the age group 25 to 34, there are 6.3 persons per 100 in this group admitted to a hospital during one year, for an average stay of 8.9 days. In the age group 55 to 64, there are 13.8 persons per 100 admitted, and their stay averages 14 days. And, he pointed out, this latter group generally are employed persons, younger than the over 65 age group that will use the hospital even more.

There will be an increasing demand for higher standards in hospitals by patients and by doctors, he said. "People are becoming medically sophisticated. They will not be satisfied without the best and latest methods of care," he commented.

The increase in the number of specialists, who are more dependent on the hospital and use more hospital services, is another factor that must be considered, Mr. Brown said.

In 1957, 70 per cent of the population had some form of hospital insurance, he stated. "Last year coverage increased three times faster than the population increase," he said. This rise in number of persons covered by hospital insurance will add to the total budget of the community. Prepayment means an automatic increase in costs without necessarily increasing the quality, because of administrative expenses, he said. For example, a few cents of each dollar paid to Blue Cross and a somewhat larger amount of each dollar paid to commercial insurance companies go for this purpose. "The cost of the community's and the nation's bill will go up every time another person is insured, because of the cost of underwriting," he said.

Not only the quantitative increase but also the demand for qualitative improvement in insurance coverage will increase costs, he pointed out.

Persons covered by hospital insurance are admitted to the hospital oftener, and stay longer, he said. Studies show that, of persons who have insurance coverage, 14 per 100 were admitted to hospitals in one recent year; of those without insurance, nine per 100 entered hospitals. Stays averaged 100 days per 100 persons covered by insurance, and 70 days

per 100 persons not covered. He added that he does not consider these differences necessarily the result of abuse of hospital insurance. Prepayment should be used, he said, commenting: "Why should people have insurance if they don't use it?"

Under the general heading of medical advances, Mr. Brown discussed a number of factors that will add to the community's health bill.

Persons are being admitted to hospitals today for treatment who would have died at home several years ago, he said. Cases once considered inoperable or untreatable now are not always so; they are brought to the hospital if there is some chance, however small, to save them. Here again, a medically sophisticated public will demand that this be done, he said, and many of these cases, such as cancer or heart surgery patients, are the hardest to treat and most expensive.

Integration of services into the general hospital will increase, Mr. Brown said. The costs of caring for mental patients and tuberculosis cases previously have been borne by the state, and people were willing to pay taxes to carry out this health protection, or police, function of the state. However, this function of the state is now being brought into the general hospital, he said, and will increase the proportion of community resources that must be placed in the hands of the voluntary hospitals. Hospitals will have to take tuberculosis cases, and medical advances such as tranquilizers mean that general hospitals can treat almost any mental patient, he said. And, said Mr. Brown, the demand will increase for this under Blue Cross coverage of acute intensive care. Treatment will cost more in the general hospital and the need for beds will increase, Blue Cross expenses will go up, and the community will have to provide more money.

The rehabilitation function, which the public also will demand, will add to the total budget, since rehabilitation means the hospital becomes the site of continued treatment and must bear the expense for the patient's life.

Legal and social influences will be brought to bear on hospitals, Mr. Brown continued.

The growing trend toward loss of immunity means that hospitals will lose more court suits, damages assessed against hospitals will become larger, and malpractice insurance costs will increase.

The tax exemption for hospitals will decline, Mr. Brown predicted, adding that, more and more, hospitals are being taxed for various purposes.

Hospital-professional relations will affect costs. As more specialists, such as radiologists and pathologists, col-

now

STERILE PACKAGED

BARDEX® FOLEY CATHETERS

READY FOR INSTANT USE
WITHOUT PROCESSING OR AUTOCLAVING

Saves time, labor and nuisance—no delays for processing and autoclaving, no problem of trying to anticipate and process in advance the sizes that may be needed. No waits at time of emergency!

Saves money—eliminates the costly steps of processing and sterilizing—gives a *known fixed* catheter cost.

Convenient—simplifies the catheter inventory control problem for Central Supply. Requisitions can be filled *at once*—the right size catheter, easy to open, sterile, ready for instant use.

Write for illustrated brochure . . .

C. R. BARD, INC. • SUMMIT, N. J.

581

lect their own bills, hospitals will not be able to offset low room charges by money brought in from these specialties. Room rates will be forced up, and the specialty rates will stay the same, he said.

The upgrading of nursing schools by state boards will result in higher costs. Here again, the community does not blame the educational process, it blames hospitals for the additional burden, he said.

Under the heading of cultural influences, Mr. Brown considered the increased number of women, especially married women, now in the labor force. With women now working who formerly stayed at home and could care for the sick, there are no resources in the home to delay admission of a patient to a hospital or to speed his discharge.

It is possible to correlate the use of hospital care with the educational level of the population, he said. The best educated persons use the hospital more than uneducated persons, for various reasons. Because the percentage of the population that will be educated will increase, the community health budget will be greater.

MUST BE NATIONAL MECHANISM

In response to a question about costs of geriatric care, Mr. Brown said that there must be a national mechanism that will provide a system of reserves to pay for the hospitalization of aged persons, built up by the worker from the time he enters the work force. Unless such a reserve is accumulated over the worker's lifetime, he explained, it would be impossible for the amount of hospital care he needs after he retires to be paid out of his contributions.

Also, geriatric, or subacute, care is an area where the denominational hospital can pioneer, he said. Prepayment has been accepted by the public for acute care, but not for subacute care, and denominational funds might be used successfully to provide this latter type of care, he contended.

John Stagl, assistant director of Passavant Memorial Hospital, Chicago, and a participant in the panel discussion that followed Mr. Brown's talk, pointed out that not only will many new hospital facilities be necessary, but also that replacement of existing facilities will be needed. Depreciation charged to patients for buildings must be put on a more realistic basis, he said. Hospitals cannot hope to make a dramatic reduction in costs to patients by work simplification or methods improvement, he asserted. Often, a great reduction in costs means reduced standards, which would be a much bigger public relations problem, he said.

Methodists' Association Names Victor B. Hann as New President-Elect

CHICAGO. — Dr. Victor B. Hann, superintendent of Methodist Home for Children, Mechanicsburg, Pa., was named president-elect of the National Association of Methodist Hospitals and Homes at the organization's annual meeting here last month. Denominational meetings were held in conjunction with the American Protestant Hospital Association.

New president is the Rev. Harold E. Baker, administrator of San Diego Methodist Home, Chula Vista, Calif. He succeeds Ralph M. Hueston, superintendent of Wesley Memorial Hospital, Chicago.

Other officers are: vice president, Dr. Bolton Boone, administrator of Methodist Hospital of Dallas, Tex.; secretary, the Rev. Floyd N. Drake, administrator of M. J. Clark Memorial Home, Grand Rapids, Mich., and treasurer (reelected), the Rev. William A. Hammitt, executive director of Baby Fold, Normal, Ill.

Robert H. MacRae, executive director of the Welfare Council of Metropolitan Chicago, outlined several steps to relieve the shortage of trained personnel for health and welfare agencies, including an organized program to encourage young people to enter health and welfare careers; enlisting the services of former professional social workers whose families are now grown; reexamination of salary levels, which he said are extremely low in relation to training needed and responsibilities carried, and better utilization of trained personnel now available.

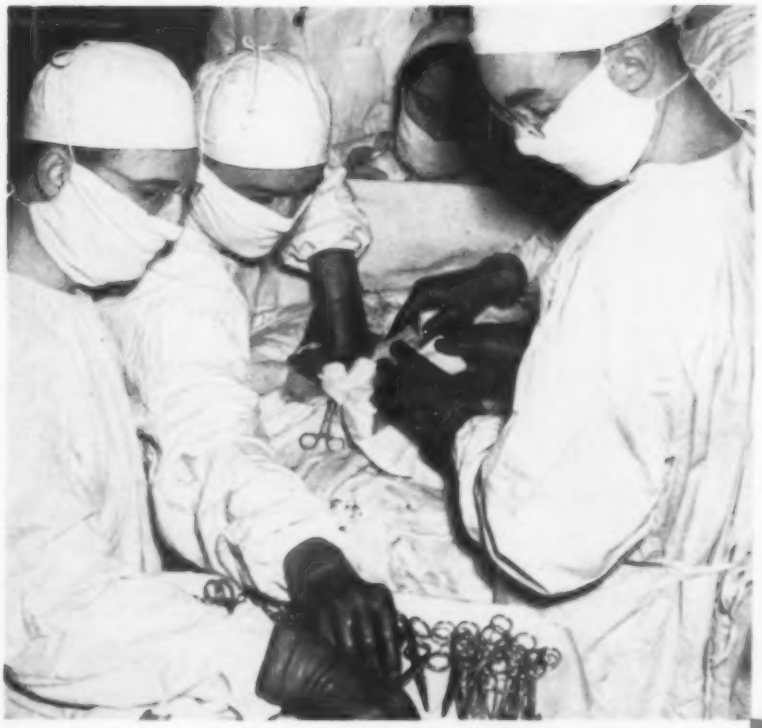
Bishop Richard C. Raines, head of the Indiana area of the denomination, spoke to the delegates at an evening banquet, and urged Methodist hospitals to take the lead in extending privileges to patients and to nurses and doctors without racial discrimination.

In a hospital section meeting, B. O. Lyle, administrator of Methodist Hospital, Omaha, Neb., described his hospital's intensive care unit, which was completed in April 1957. Chief advantage of the unit, Mr. Lyle said, is that total nursing care can be equalized. When the general floor nurses are relieved of the care of the acutely ill patients, complaints from other patients who feel they are being neglected are eliminated. Since the hospital's recovery room is open only one shift per day, five days a week, the intensive care unit also functions as a recovery room after these hours. At least three to four weeks should be spent on a concentrated education program for the medical staff, personnel to be staffing the unit, and the public, Mr. Lyle said.

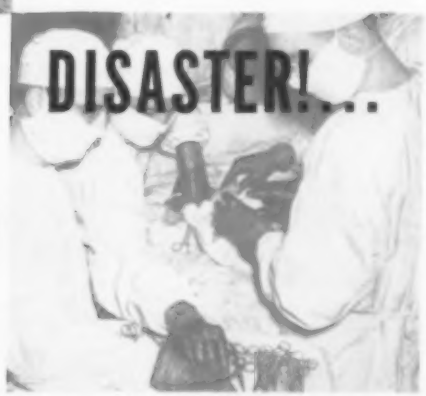
Discussing new trends in psychiatric treatment, nursing and facility planning, Laurence B. Hutson, executive director of North Shore Hospital, Winnetka, Ill., predicted that ultimately every general hospital will have a psychiatric unit, with the goal of reintegrating the patient into the community environment.

Stanley R. Nelson, administrator of Parkview Memorial Hospital, Fort Wayne, Ind., discussed the value of the methods engineer, or person trained in methods improvement, to the hospital. The methods engineer has the working tools of task lists, time and motion charts, flow charts, work distribution charts, and layout diagrams to aid the hospital. It is more efficient to give one person the responsibility for carrying out an organized program rather than attempting to use the time of already busy department supervisers, he said.

Barbara Bowman, senior student in the Methodist Hospital School of Nursing, Houston, Tex., was named Miss Methodist Student Nurse. Miss Bowman was chosen from students representing Methodist hospitals throughout the country.



one tiny spark could bring



APPLETON explosion-proof equipment gives you positive, up-to-date protection against explosion and fire hazards!

(U.L. approved for all hazardous areas in Class I, Groups C and D)

The specialized talent of APPLETON'S engineering department backed by practical experience gained in years of analyzing hospital explosion-proof requirements make APPLETON explosion-proof equipment your finest buy . . . your safest buy. There has grown around the APPLETON name, a considerable reputation in the hospital and architectural field for installations which require the barest minimum of maintenance. This factor is extremely important in that it assures you a lifetime of trouble-free operation and enables you to expand your initial purchasing estimates to include *everything you need*. Consult your electrical contractor for a safety check on your explosion-proof needs, and remember to specify APPLETON . . . the quality name in explosion-proof equipment.

X-ray film illuminators for hazardous or non-hazardous locations.

Receptacle with plug.

Two-gang Pilot Lights. Available in single gang and in combination with switch.

Two gang Switch Unilet. Single gang model also available.

Portable Current Tap with feed-in plug.

Sold Through Franchised Wholesalers Only

APPLETON ELECTRIC COMPANY *1743 Wellington Ave. · Chicago 13, Ill.*

Protestant Hospitals Choose Edwin B. Peel as President-Elect

CHICAGO. — Edwin B. Peel, administrator of Georgia Baptist Hospital, Atlanta, was named president-elect of the American Protestant Hospital Association during the group's annual meeting here last month.

Paul R. Hanson, administrator of Emanuel Hospital, Portland, Ore., was installed as president, succeeding Albert G. Hahn, administrator of Protestant Deaconess Hospital, Evansville, Ind.

Other officers are: 1st vice president, Brig. Jane E. Wrieden, administrator, Booth Memorial Hospital, Cleveland; 2d vice president, Elmer W. Paul, administrator of Burge Hospital, Springfield, Mo.; treasurer (reelected), C. E. Copeland, administrator of Missouri Baptist Hospital, St. Louis. Leo M. Lyons is executive director.

New trustees are: 1959, Albert G. Hahn and the Rev. Fred A. Springborn, chaplain at Norton Memorial Infirmary, Louisville, Ky., who will fill the unexpired term of Jane E. Wrieden; 1961, the Rev. Frank Prentzel Jr., executive secretary of Methodist Episcopal Hospital, Philadelphia; John C. Eller, administrator of Bethany Hospital, Chicago, Robert W. Bachmeyer, administrator, St. Barnabas Hospital, Minneapolis; the Rev. A. H. Schmeuszer, administrator of Evangelical Deaconess Hospital, Milwaukee, and the Rev. Carl R. Plack, National Lutheran Council, Washington, D.C.

The convention was held in conjunction with the Chaplains' Association of the A.P.H.A. and denominational groups of the Baptist, Methodist, Lutheran, Presbyterian, Mennonite, Episcopal, and Evangelical and Reformed churches and the Salvation Army.

Hospital Housekeepers Offered 10th Short Course

CHICAGO.—The tenth annual short course in hospital housekeeping will be held from March 31 to May 23 at Michigan State University, sponsored by the American Hospital Association, it is announced. Enrollment is limited to 40 students.

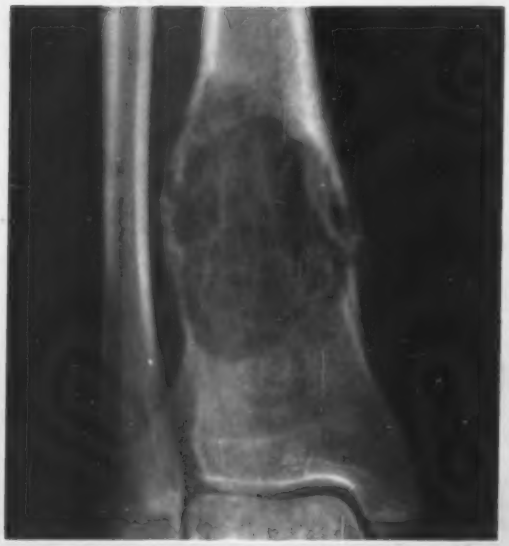
The course is designed to provide practical training in up-to-date housekeeping procedures for executive housekeepers, members of hospital housekeeping staffs, and prospective employes. Subjects will include philosophy of hospital care and institutional organization, personnel management, institutional management, and housekeeping supplies, equipment and procedures.

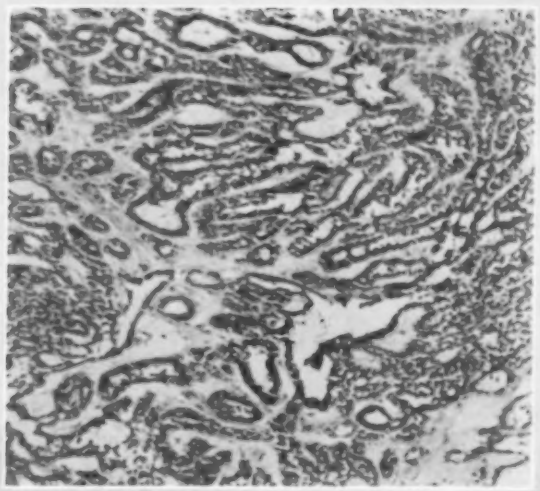
Council to Give First Test

CHICAGO.—The Educational Council for Foreign Medical Graduates has announced that its first examination will be held March 25, in the United States only. The examination March 25 is designed to give foreign medical graduates now in the United States an opportunity to achieve Council certification and to test the examination and procedures before the program is inaugurated in foreign centers. A second examination will be held September 23 in approximately 30 centers throughout the world.

Need Public Health Nurses

NEW YORK.—More than 40,000 public health nurses will be needed by 1970 to bring the ratio of these nurses up to 20 per 100,000 population, a new study by the National League for Nursing has reported. There are 28,000 public health nurses today, the report said, and the ratio is 16.5 per 100,000 persons, the highest ever reached.





ADAMANTINOMA . . . 3 aspects

Radiograph *(upper left)* showing an adamantinoma in the lower end of a tibia in a man of 48 years. The lesion has caused lytic destruction and expansion of the contour of the affected part of the bone.

Photograph *(upper right)* of frontal section of specimen. The adamantinoma tumor tissue was clearly demarcated from the spongiosa. It was tough and firm but presented small areas of cystic degeneration.

Photomicrograph (x 90) *(left)* showing the alveolar glandular pattern so characteristic of certain fields of an adamantinoma.

Turn page for data on Osteogenic Sarcoma.

Radiography and Photography work together

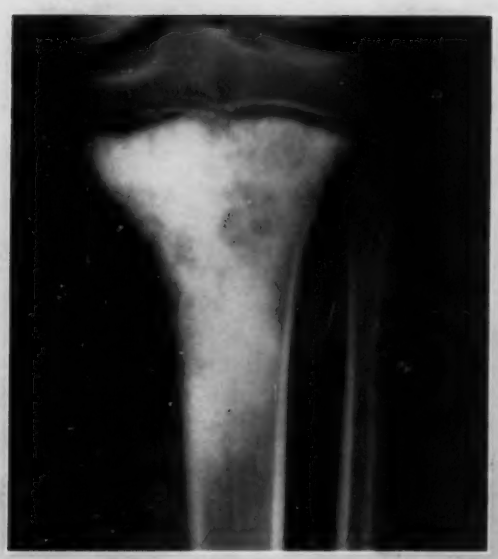
...for physicians, teachers, researchers

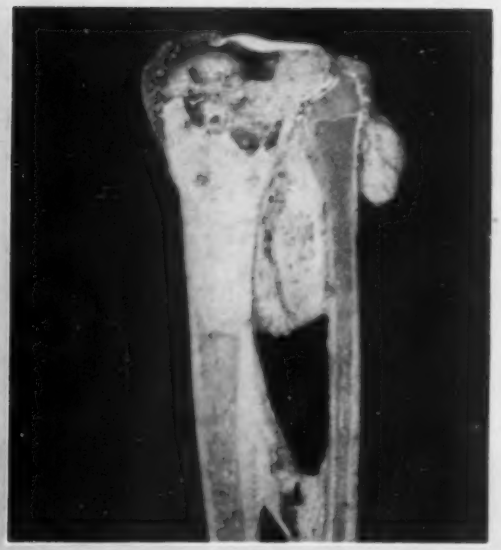
Every case documented with *both* radiographs and photographs is sheer gain for the medical profession.

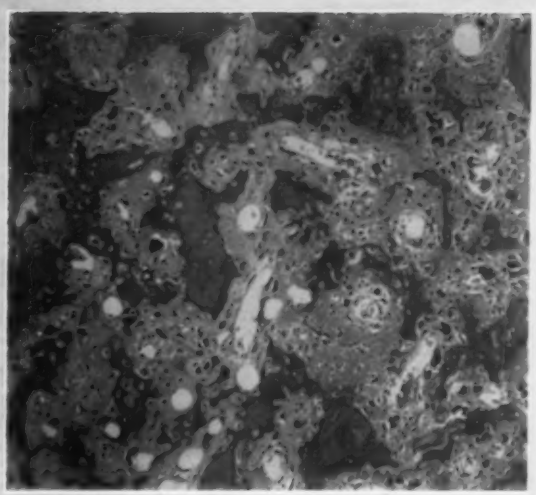
With material such as this, the attending physician is ready to share his case with associates and students . . . ready to lecture or publish . . . ready, thus, to tell the world —today, tomorrow, years later.

Photographs are easily obtained. Equipment requirements are minimal. Film costs, remarkably small in relation to the value of full documentation.

Kodak
TRADEMARK







OSTEOGENIC SARCOMA . . . 3 aspects

Radiograph *(upper left)* **of a highly ossifying osteogenic sarcoma in the upper part of the shaft of tibia of a boy of 10 years.**

Photograph *(upper right)* **of longitudinal section of tibia shown in radiograph above. Part of the cortex and epiphyseal plate have been destroyed, but the epiphysis is still not invaded.**

Photomicrograph (x 70) *(right)* **showing an osteogenic sarcoma tissue field in which a considerable amount of calcifying intercellular material has been laid down between the tumor cells.**

For Radiography: Kodak Royal Blue X-ray Film and Kodak x-ray processing chemicals are uniform, dependable. Quality-controlled—rigidly tested—they are *made to work together.*

For Color Photography: Kodachrome Films for miniature and motion-picture cameras; Kodak Ektachrome Films and Kodak Ektacolor Films for sheet-film cameras; Kodak Ektachrome Films for roll-film and miniature cameras; Kodacolor films for roll-film cameras and cameras accepting No. 828 film. Kodak color print materials are also available.

Order Kodak x-ray products from your Kodak x-ray dealer, Kodak photographic products from your Kodak photographic dealer.

EASTMAN KODAK COMPANY, *Medical Division,* Rochester 4, N. Y.

Kodak

Serving medical progress through Photography and Radiography

1000 Delegates Attend Second Illinois Congress on Maternal, Infant Care

PEORIA, ILL.—Approximately 1000 people with just one idea among them gathered here February 4 to 6 to talk about their pet idea: the need to give better care to mothers and infants. Delegates attending the Second Illinois Congress on Maternal and Infant Care heard many cogent opinions and recommendations on how to achieve this goal offered by representatives of medicine, nursing, public health, social service, and hospital administration.

Subjects covered included everything from the dietary needs of pregnancy through the education of parents (an area in which hospitals need to do a better job, it was agreed) up to the care of the infant, both premature and full term.

Because the current invasion of staphylococcus infections is causing considerable anxiety to doctors and hospital officials alike, several sessions were devoted to the problems involved. The state health officers held the center of the stage at each of these meetings and their views on the best methods of checking epidemics were sought with a flattering deference that is not always accorded public health officials.

Dr. Ruth E. Church, deputy director of the Illinois Department of Health, in charge of the Division of Hospitals and Chronic Illness, mentioned that she was as happy to see so much attention being given to hospital infections at this meeting as she had been distressed at the lack of attention last year. "In other words, we are just about a year late getting around to it." Dr. Church and her colleagues in public health urged a better system of discovering and reporting infections, both within the hospital and to the public health agencies.

Every speaker stressed the need for tighter control of nursing personnel, both professional and nonprofessional, in order to prevent breaks in technic.

"The things a doctor sees in the nursery you wouldn't believe," a woman doctor commented in a section meeting on nursery personnel. "I've seen a registered nurse dip her hands in a stopped-up sink full of dirty water—and insist she had washed her hands between caring for one baby and the next, as she's supposed to. She just wouldn't bother to go to another sink!"

The doctor's compliments about nursing technics were returned with interest by several nurses who took an equally dim view of the doctors' methods in the nursery examining

Barnstead Briefs

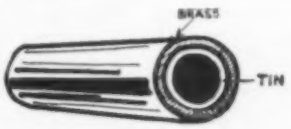
A COLUMN DEVOTED TO THE LATEST WATER PURIFICATION DEVELOPMENTS IN THE HOSPITAL

YOUR WATER STILL

The Spanish Prison Baffle located between the evaporator and the condenser in Barnstead Type "Q" Hospital Stills removes minute entrainment from the steam. Developed by Barnstead engineers, in cooperation with Dr. Lee A. Rademaker, the Spanish Prison Baffle makes possible the consistent production of the purest, pyrogen-free water from a single distillation . . . highest purity because as the vapors pass through the maze of baffles and traps, they are stripped of even the most minute particles.

KEEPING DISTILLED WATER PURE

A crucial problem in the use of distilled water develops from the time it is received from the Water Still to actual usage. To prevent this metallic contamination, Barnstead has developed a complete line of pipe and fittings including draw-off valves. Although only freshly distilled water is used in intravenous work, such a distilled water distribution system can provide distilled water in convenient locations for many hospital uses, thereby saving time and money.



OPERATING AND MAINTENANCE HINTS

All Barnstead Type "Q" Hospital Stills are equipped with a "bleeder valve" which continuously deconcentrates impurities within the evaporator. Where the raw water is high in bicarbonates, however, this bleeder valve should be closed. Bicarbonates tend to precipitate out of solution at temperature exceeding 150°F. More frequent draining and cleaning of the evaporator is required when the bleeder valve is closed.

FIELD REPORTS

Barnstead's new Ultra Violet Tank has undergone numerous tests to prove its effectiveness. Latest report from the research laboratories of Skinner & Sherman, Inc., Boston, include the following statement: "The ultra violet light will kill spore-forming organisms that might accidently be introduced into the tank . . . within two hours. In addition to these tests, we held distilled water in the tank with ultra violet light on for a 30-day period and examination of the water showed the material to be sterile."

WOULD YOU BELIEVE

The late Admiral Richard E. Byrd, Antarctic explorer and scientist, on both of his first two trips to the South Pole brought along Barnstead Water Stills. They were indispensable for medicinal purposes, for battery water, and as a source of drinking water.

NEW PRODUCT

The New Barnstead Paraffin Dispenser for supplying pathological and other labs with a ready supply of hot paraffin has proven a recent boon to busy pathologists and other technicians. Developed in cooperation with the Pathological Laboratories at the Massachusetts General Hospital, this dispenser will save time and money in every laboratory that does tissue embedding. Eliminates need for hot plates, beakers, pitchers, and storage ovens. For further information write to: Barnstead Still & Sterilizer Co., 25 Lanesville Terrace, Boston 31, Mass.

room. Aside from a few such exchanges, however, both doctors and nurses were soberly agreed that the situation is frightening and something had better be done.

As is the case at every hospital meeting, the subject of the nursing shortage and its effects on patient care was examined from many angles. The angle presented by Dr. C. Lee Buxton, professor and chairman of the department of obstetrics and gynecology, Yale University School of Medicine, had many of the doctors present muttering about "going back to the dark ages of medicine" and being "right back where we were years ago." Dr. Buxton advocates the use of a highly specialized kind of nurse—the nurse-midwife. There are five schools of nurse-midwifery in the country now (Yale has one of them) and Dr. Buxton thinks there is a need for more. Aware of the "unfortunate connotations" of the term midwife, the speaker suggested calling this specially trained person a nurse-obstetrician.

Explaining the services the nurse-obstetrician would render, Dr. Buxton stated: "I would hazard a guess that the majority of deliveries are carried out in this country in labor and delivery room units where the assistance of a house officer is only occasionally available, if at all. Would it not be a tremendous advantage under these circumstances to have as delivery room supervisor a graduate nurse who has had at least one year of concentrated training in theoretical and practical obstetrics? She would then be competent to follow patients through labor, to evaluate the progress of labor by rectal or sterile pelvic examination, to recognize danger signs immediately, if and when they do occur, and even under certain emergency circumstances to scrub and assist in a delivery and postoperative or postpartum care."

In view of the desirability of isolating obstetrical patients, how can a hospital still make the best use of unused beds? The question was put to Dr. Hilda H. Kroeger, administrator, Elizabeth Steele Magee Hospital, Pittsburgh, who offered six suggestions for making the greatest use of obstetrical beds, as follows:

1. Preregistration of patients so that the case load can be anticipated.

2. Daily scrutiny of admissions to obstetrics and of the obstetrical census.

3. Provision of labor room to which patients can be directly admitted. This prevents the tying up of a postpartum bed until after the patient has been delivered.

4. Close working relationship with physicians so as to shorten patient stay and postpone inductions at peak census periods.

5. Removal of mothers without babies from the obstetrical floor at the time of peak census.

6. Making most of the accommodations on the maternity floor similar. Maternity patients are usually happy in rooms with two or more beds.

New officers elected by the Illinois Committee on Maternal Welfare, which presented the congress, are: chairman, Dr. Willard C. Scrivner, Washington University, St. Louis; vice chairman, Dr. Heyworth N. Sanford, Chicago; chairman-elect, Dr. Julius M. Kowalski, Princeton, Ill.; secretary, Arlene S. Krieger, R.N., Chicago, and, treasurer, George K. Hendrix, administrator, Memorial Hospital of Springfield.

The congress was sponsored by the American Association for Maternal and Infant Health.

Public Health Statistics

ANN ARBOR, MICH.—The first summer program in public health statistics will be offered at the University of Michigan from July 19 to August 1, it was announced recently. Elementary, intermediate and advanced courses will be offered.

COMING EVENTS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Institutes: 8th New York, New York, June 23-27; 8th Western, Palo Alto, Calif., June 23-27; 26th Chicago, University of Chicago, Sept. 2-12; 9th Chicago Advanced, University of Chicago, Sept. 8-12.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Members Conferences: Regions 17, 18, Montreal, Que., April 14-18; Region 11, Kansas City, Mo., Oct. 20-24; Region 10, Minneapolis, Oct. 27-31; Region 1, Boston, Nov. 10-14; Region 8, East Lansing, Mich., Nov. 17-21.

AMERICAN HOSPITAL ASSOCIATION, convention, Palmer House, International Amphitheater, Chicago, Aug. 18-21.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Boston, Oct. 26-29.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Schroeder Hotel, Milwaukee, June 15-20.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May.

ASSOCIATION OF OPERATING ROOM NURSES, Bellevue-Stratford Hotel, Philadelphia, Feb. 10-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 21-24.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 28-31.

CALIFORNIA HOSPITAL ASSOCIATION, Biltmore and Miramar Hotels, Santa Barbara, Oct. 22-24.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24, 25.

CATHOLIC HOSPITAL ASSOCIATION, Atlantic City, N.J., June 21-26.

COMITÉ DES HÔPITAUX DU QUEBEC, Montreal Show Mart, Montreal, Que., June 25-27.

CONNECTICUT HOSPITAL ASSOCIATION, Berlin Light and Power Co., Berlin, June 11.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Claridge, Atlantic City, May 21-23.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, May 21-23.

IDAHO HOSPITAL ASSOCIATION, Elks Temple, Boise, Oct. 20, 21.

INDIANA HOSPITAL ASSOCIATION, Indiana Student Union Building, Indianapolis, Oct. 8, 9.

IOWA HOSPITAL ASSOCIATION, Savery Hotel, Des Moines, April 24, 25.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 13, 14.

KENTUCKY HOSPITAL ASSOCIATION, Sheraton-Seelbach Hotel, Louisville, April 15-17.

LOUISIANA HOSPITAL ASSOCIATION, Bellemont Motor Hotel, Baton Rouge, March 20-22.

MAINE HOSPITAL ASSOCIATION, Samoset Hotel, Rockland, June 10, 11.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, May 15.

MICHIGAN HOSPITAL ASSOCIATION, Grand Hotel, Mackinac Island, June 17, 18.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., March 24-26.

MINNESOTA HOSPITAL ASSOCIATION, Lowry Hotel, St. Paul, Nov. 7.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Heidelberg, Jackson, Oct. 23, 24.

MISSOURI HOSPITAL ASSOCIATION, President Hotel, Kansas City, Nov. 19-21.

MONTANA HOSPITAL ASSOCIATION, Havre, Sept. 15, 16.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Hotel del Coronado, Coronado, Calif., April 14-18.

NATIONAL GERIATRICS SOCIETY, 5th annual convention and exposition, Henry Hudson Hotel, New York, May 13-15.

NEBRASKA HOSPITAL ASSOCIATION, Omaha, Oct. 23, 24.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.

NEW ENGLAND HOSPITAL ASSEMBLY, Institute on Housekeeping in Hospitals, Hotel Statler, Somerset, Boston, April 21-25.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 21-23.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, March 10-12.

NORTH DAKOTA HOSPITAL ASSOCIATION, Gardner Hotel, Fargo, April 22, 23.

OHIO HOSPITAL ASSOCIATION, Netherland-Hilton Hotel, Cincinnati, March 10-13.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

OREGON ASSOCIATION OF HOSPITALS, Oct. 13, 14.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Marvin Hughitt Hotel, Huron, April 7, 8.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Fontainebleau, Miami Beach, Fla., May 14-16.

TENNESSSEE HOSPITAL ASSOCIATION, Hotel Patton, Chattanooga, March 13-15.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, May 5-8.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 29-30.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium and Leamington Hotel, Minneapolis, May 14-16.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 14-16.

WASHINGTON STATE HOSPITAL ASSOCIATION, Winthrop Hotel, Tacoma, Oct. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.

ABOUT PEOPLE

(*Continued From Page* 100)

Leonard R. Piccoli has been appointed administrative assistant at Montefiore Hospital, New York. Mr. Piccoli recently was discharged from the medical service corps of the army. He is a graduate of the hospital administration course at Columbia University, and served his administrative residency at Montefiore Hospital.

Allen Podell has been appointed assistant administrator of Brooklyn Hebrew Home and Hospital for the Aged, Brooklyn, N.Y. He formerly was assistant administrator of Kings Highway Hospital, Brooklyn, N.Y., and served his administrative residency at Brooklyn Jewish Hospital.

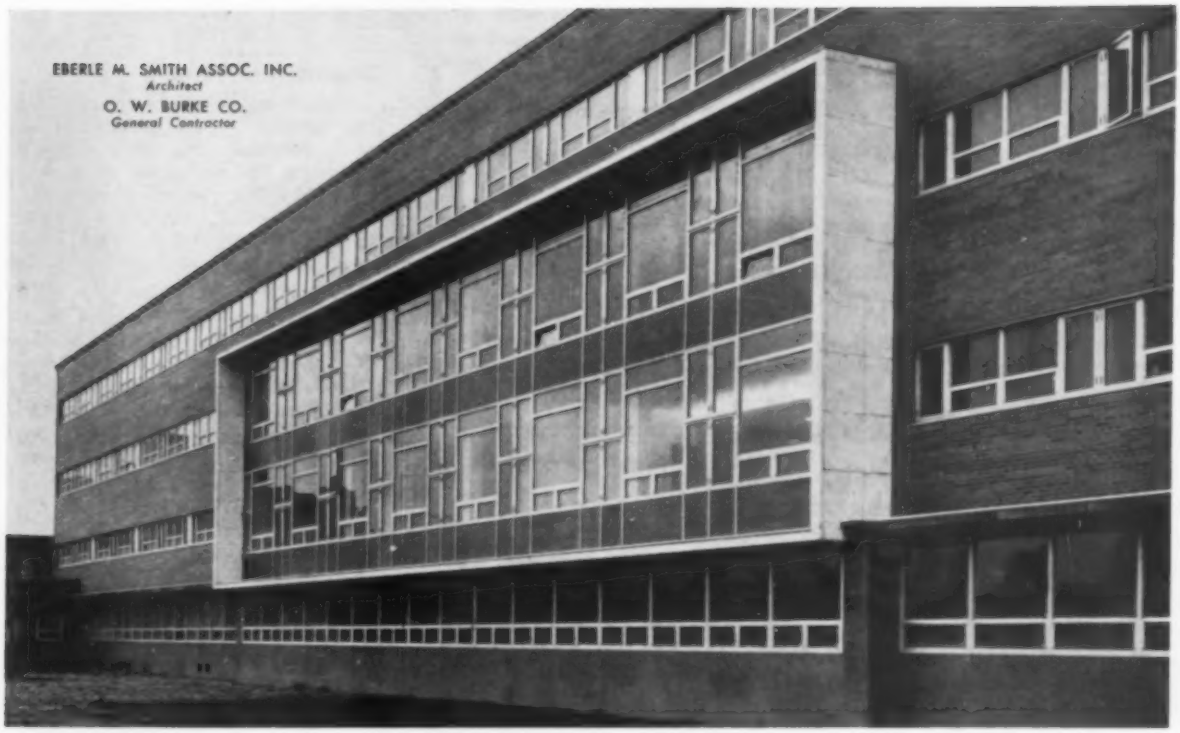
Gerard A. Ouellette has been appointed administrator of Cape Cod Hospital, Hyannis, Mass. Mr. Ouellette, who has served as assistant administrator of Grace-New Haven Community Hospital, New Haven, Conn., since 1953, is a graduate of the Yale University hospital administration course and Mills School of Nursing, New York.

Robert Paulsen, business manager of St. Elizabeth Hospital, Baker, Ore., has been appointed administrator of Pioneer Memorial Hospital, Prineville, Ore., succeeding **Ethel Elliott.** Mr. Paulsen is president of the Oregon chapter of the American Association of Hospital Accountants and president of the Eastern Oregon Area Council of the Oregon Association of Hospitals.

James R. Donachie, special assistant to the manager of the Veterans Administration hospital in Salt Lake City, has been named assistant manager of the V.A. hospital in Roseburg, Ore. Mr. Donachie is a graduate of the State University of Iowa's hospital administration course and holds a master's degree in education from the University of Southern California. He is a nominee of the American College of Hospital Administrators.

Dr. George M. Leiby, manager of Veterans Administration Research Hospital, Chicago, has been transferred as area director of professional services in the Columbus, Ohio, V.A. area medical office. He will be succeeded by **Dan J. Macer,** manager of the V.A. hospital in Sunmount, N.Y. **Reuben Cohen,** manager of the V.A. center at Kecoughtan, Va., will succeed Mr. Macer.

Manuel Segall has been named administrator of the newly founded Central Community Hospital, Chicago. Mr. Segall, a graduate of the hospital



VAMPCO ALUMINUM WINDOWS AND CURTAIN WALLS ACCENTUATE MODERN DESIGN OF THE NEW LAFAYETTE CLINIC

The new Lafayette Clinic in Detroit, Michigan is a beautiful example of how architects throughout the nation are incorporating modern Vampco Aluminum Curtain Walls and Aluminum Windows to combine full natural lighting, modern beauty, functional design, structural strength and durability in the new concepts of modern hospital design.

Note how the Curtain Wall section in the center of this magnificent hospital building accentuates the modern lines and the unusual lighting and ventilating of the building itself.

Vampco Aluminum Windows are available in the widest range of types to meet every architectural need. They include: casement, combination casement, awning, intermediate projected, curtain wall of varying sizes and thicknesses, heavy construction, glass block and custom-designed types. Find out how VAMPCO'S special designing service can help you solve your unusual building problems most economically and efficiently . . . mail coupon below today!

VALLEY METAL PRODUCTS CO.

PLAINWELL, MICHIGAN

SUBSIDIARY OF
MUELLER BRASS CO.
PORT HURON, MICHIGAN

See Complete File in Your Current Sweet's Catalog

VAMPCO

A NAME THAT MEANS THE VERY FINEST IN LIFELONG ALUMINUM WINDOWS

VALLEY METAL PRODUCTS COMPANY
Dept. MH-38, PLAINWELL, MICH.

- ☐ Send 56-page Industrial-Institutional Window Catalog.
- ☐ Send Light Construction Aluminum Window Catalog.
- ☐ Send Curtain Wall Catalog.

NAME .....
COMPANY .....
ADDRESS .....
CITY ..... ZONE .... STATE .....

administration course at Northwestern University, has served as assistant director of Mount Sinai Hospital, Chicago, and has held various other hospital administrative posts.

Lorin A. Corbin has been appointed administrator of Juab County Hospital, Nephi, Utah.

Ed Mehle has been named to head the I. W. Allen Hospital, Moab, Utah. Mr. Mehle formerly was associated with a Wyoming hospital.

John Owen Yale, assistant director of Salt Lake County General Hospital, Salt Lake City, Utah, has been appointed administrator of Memorial Hospital of Sheridan County, Sheridan, Wyo. Mr. Yale is a graduate of the University of Minnesota's hospital administration course.

Leroy L. Joseph Jr. has been named executive director of Bridgehaven, a nonresidential, day care center for patients scheduled for discharge from state mental hospitals in Kentucky. The center, which began accepting patients from Central State Hospital, Lakeland, Ky., last month, is located near the University of Louisville campus. Mr. Joseph previously was a caseworker with the Jewish Social Service Agency, Louisville, and a staff member of the Jewish Family and Community Service Agency, Chicago.

Department Heads

Olga Wasylyk has been appointed head dietitian at Good Samaritan Hospital, Portland, Ore. Miss Wasylyk previously had served as dietitian at Grace Hospital, Detroit; Temple University Hospital, Philadelphia, and Flower Hospital, Toledo, Ohio. She received a master's degree from Wayne State University.

Wanda Langum has been appointed chief dietitian of Sherman Hospital, Elgin, Ill., succeeding **Lorraine Rakow,** who resigned after six years of service. Miss Langum formerly was an administrative dietitian at Passavant Hospital, Chicago, for 12 years.

A. William Hammarstrom has been named purchasing agent of Little Company of Mary Hospital, Evergreen Park, Ill. He formerly was purchasing agent of Brockton Hospital, Brockton, Mass.

Edward E. Hartselle has been appointed chief engineer at Alexandria Hospital, Alexandria, Va. Previously, Mr. Hartselle was associated with Winchester Memorial Hospital, Winchester, Va., for six years.

Dr. Otto P. Berdach has been named clinical director of East Moline State Hospital, East Moline, Ill. Dr. Berdach has been associated with the Veterans Administration hospital at Northampton, Mass. He is a diplomate of the American Board of Psychiatry and Neurology.

John F. Clark, controller of Grant Hospital, Chicago, has been appointed director of finance at St. Bernard's Hospital, Chicago. Mr. Clark is a graduate of the Northwestern University's hospital administration course.

Irene M. Murphy has been named social service director of Staten Island Hospital, Staten Island, N.Y. Miss Murphy has been psychiatric counselor for the Staten Island Mental Health Society for the last year and a half. She is a graduate of Fordham University.

Miscellaneous

Florence S. Schorske, assistant professor of psychiatric nursing at Yale University School of Nursing, has been appointed acting dean of the nursing school, effective July 1. Miss Schorske will succeed **Elizabeth S. Bixler,** who is retiring as dean after serving in the post since 1944 and as a member of the Yale faculty since 1927. In addition to holding various nursing administration posts in hospitals, Miss Bixler has been president of the Connecticut State Nurses Association, president of the Association of Collegiate Schools of Nursing, and

a director of the National League for Nursing.

Margaret F. Carroll, R.N., has been named deputy executive secretary of the American Nurses' Association, effective June 1. Mrs. Carroll, who has served on the A.N.A. staff for six years, will succeed **Judith Gage Whitaker.** Mrs. Whitaker will become executive secretary, following the retirement of **Ella Best** in June.

Jerry N. Ransohoff, former medical editor of the Cincinnati *Post* for nine years, has been appointed executive secretary of the newly reorganized Greater Cincinnati Hospital Council.

Leonard J. Zimet has joined the staff of Gordon A. Friesen Associates, hospital consultants of Washington, D.C. Mr. Zimet will serve as hospital administrator at San Juan de Dios Hospital in San Jose, Costa Rica. At the same time it was announced that **Muriel A. Poulin, R.N.,** has been named assistant hospital administrator in nursing service at the San Jose hospital. Miss Poulin formerly was coordinator of staff education at Massachusetts General Hospital, Boston.

W. Taylor Morrow has been appointed administrator of the Workmen's Compensation Board of Ontario, Hospital and Rehabilitation Center, Malton, Ont. Mr. Morrow previously was associated with the hospital consulting firm of Gordon A. Friesen Associates, Limited, Toronto. He is a graduate of the hospital administration course at Northwestern University.

Deaths

Dr. W. Franklin Wood, retired director of McLean Hospital, Waverley, Mass., and a former regent of the American College of Hospital Administrators, died suddenly January 15. Dr. Wood, who was director of McLean Hospital for more than 20 years, was a former secretary and past president of the New England Hospital Assembly and past president of the Massachusetts Psychiatric Association. He was a fellow of the American College of Hospital Administrators and the American Psychiatric Association.

Health Boards Pass Rules for Users of X-Ray Units

NEW YORK. – Registration and inspection procedures for x-ray and fluoroscopic units are expected to be adopted soon by the New York City board of health, it was reported last month by *Scope* weekly newspaper.

In its January meeting, the board ruled that only physicians, dentists and "other practitioners of the healing arts" will be permitted to use x-ray and fluoroscopy in diagnosis and treatment of illness. Shoe stores in the city are no longer allowed to use fluoroscope machines for fitting shoes, under the January ruling.

The proposed registration procedures call for the designation of a radiation safety officer in connection with the installation and operation of x-ray and fluoroscope machines. Physicians or dentists, if qualified, may act as their own radiation safety officers, according to the board.

The new part of the code also provides that x-ray and fluoroscopic equipment may be sold or leased only to persons licensed to use it or to hospitals, infirmaries and other medical institutions.

A similar registration code already has been incorporated into the Michigan Administrative Code, it was reported last month. Users of radiation equipment, including x-ray devices and isotopes, are required to register with the Michigan Department of Health. A nine-member radiation committee was appointed to formulate the regulations and will advise the state health commissioner on matters pertaining to radiation and review the regulations yearly.

LIQUI-MED

. . . New Dimension in Therapy Regulators!

Streamlined, efficient function . . . that's the new dimension you get in Liqui-Med Therapy Regulators. Designed expressly for use by hospital personnel, they provide optimum accuracy, virtually eliminate mistakes.

Stainless steel diaphragm. Nylon pointed adjusting screw prevents metallic friction . . . exclusive REGULITE adjusting cap gives error-free settings . . . 4000 lb. H.P. O_2 gauges for extra safety. Write for free literature.

FOR SAFER MORE EFFICIENT ANESTHESIA

EXCLUSIVE! THE

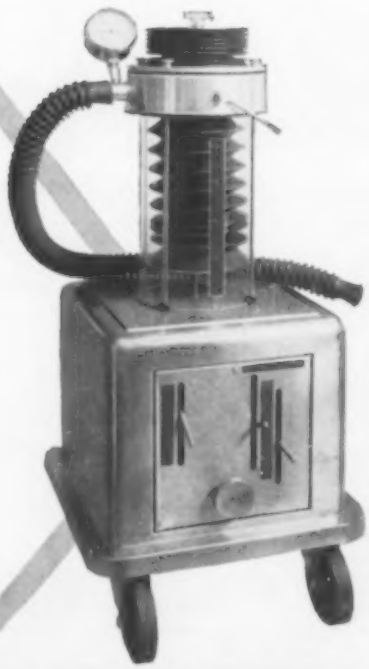
Mörch

SURGICAL RESPIRATOR

Developed by an experienced anesthesiologist who has designed respirators for many years, the Mörch respirator provides the safe, efficient, modern conditions demanded by present-day surgical techniques.

- Reduces the amount of anesthesia needed.
- Relaxes the abdominal wall.
- Provides a quieter surgical field.
- Follows patient's respiration.
- Easy adjustment of rate, pressure and volume.
- Connects to any anesthesia apparatus, or can be used without apparatus.
- Operated by compressed air or oxygen — no electrical components.
- All rubber parts are conductive.

Now exclusively represented by Liquid Carbonic. Write for full particulars.



Liqui-Med

LIQUID CARBONIC

DIVISION OF GENERAL DYNAMICS CORPORATION

3100 South Kedzie Avenue, Chicago 23, Illinois

How *high velocity* solves problem of *flexibility* in the Medical Towers

When the new Medical Towers Building in Houston, Texas was planned, the key air conditioning problem was flexibility. Professional office areas had to be subdivided *after* the building was completed. Here's how an Anemostat dual duct high velocity air distribution system solved the problem.

As shown in the diagrammatic sketch, a system of perimeter take-offs from the hot and cold ducts enables each doctor to provide the exact temperature he wants. Temperatures in the various rooms of each suite of offices can be varied. Air distribution is draftless, comfortable, perfectly suited to tenants' needs.

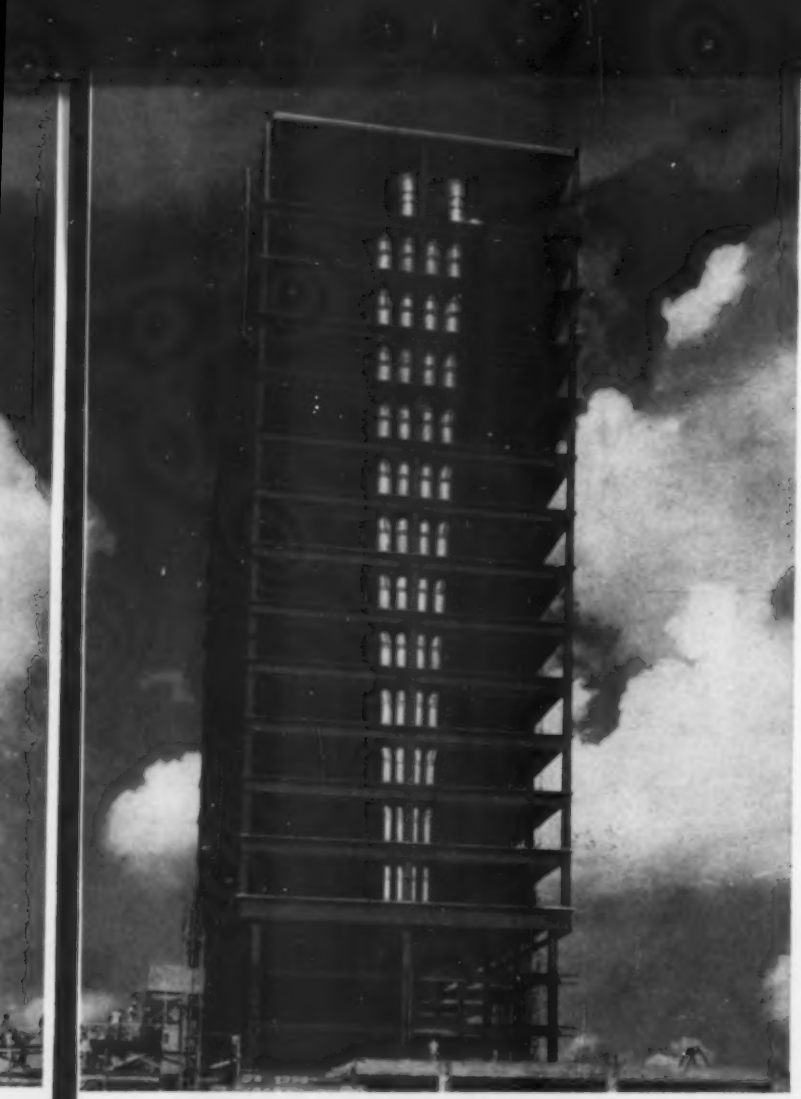
The Anemostat All-Air High Velocity distribution system offers further important advantages. It can be used with smaller than conventional ducts. It can be installed in less time and at less cost. It requires no coils, thus eliminates leakage, clogging and odors.

ARCHITECTS—Attention Please:
Anemostat round, square and straightline diffusers with high velocity units are adaptable to a wide variety of architectural designs.

Architects: Golemon and Rolfe, AIA, Houston
Consulting Architects: Skidmore, Owings and Merrill, New York
Consulting Engineers: Bernard Johnson and Associates
General Contractor: Tellepsen Construction Co.
Air Conditioning Contractors: Straus-Frank Company

Anemostat HPE units and duct connections installed in office before construction of ceiling and walls

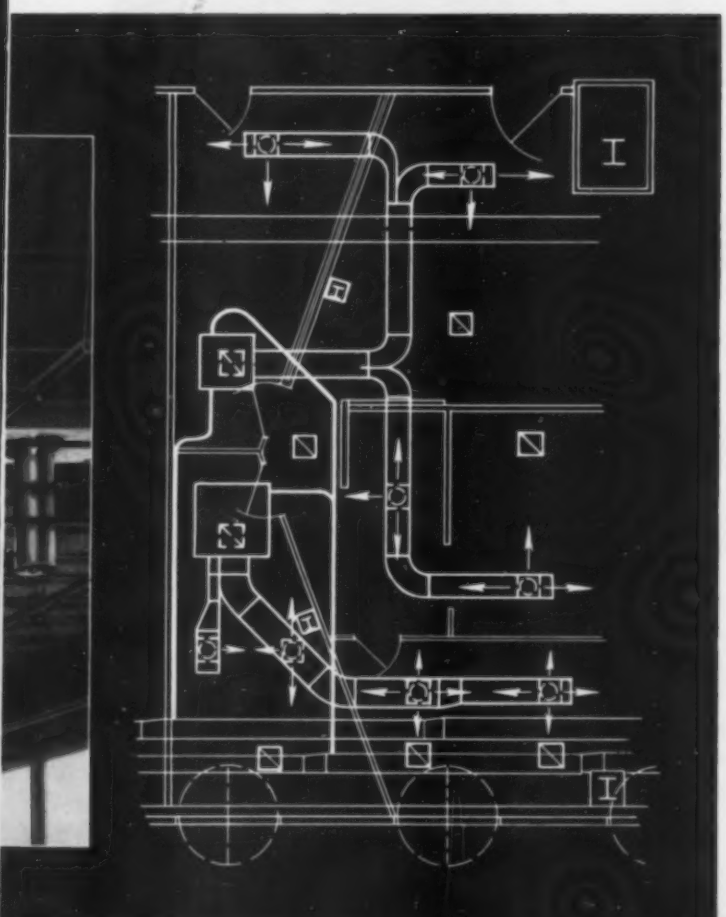
AC 1348



◀ Note how locating of hot and cold ducts saves space in new Medical Towers Building, Houston, Texas

View of lobby showing Anemostat Air Diffusers

View of professional reception room



◀ Layout of typical suite

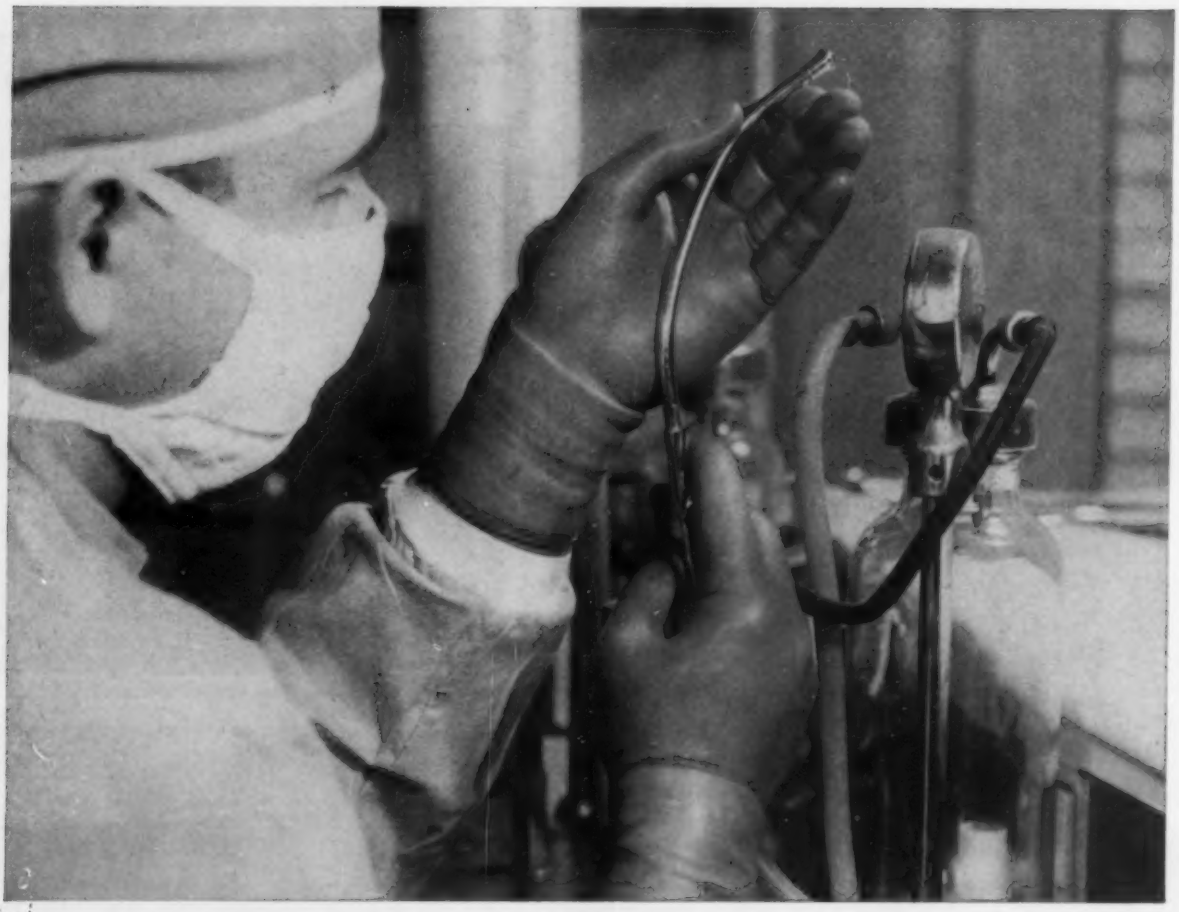
Write on your business letterhead for your copy of

New Anemostat Selection Manual 60

to Anemostat Corporation of America, 10 East 39 Street, New York 16, N. Y.

ANEMOSTAT: The pioneer of All-Air High Velocity Systems

B.F.Goodrich report:



More than 2300 surgeons are testing these "Surgiderm" gloves

Typical reports: "Much more comfortable", "Less tiring to hands"

At our invitation surgeons throughout the country are using and testing B. F. Goodrich "Surgiderm" gloves, and telling us how they fit, perform and last. The comments are still coming in, but already we can be sure that this new glove is being enthusiastically approved and accepted.

This approval is a guide to you in buying rubber gloves for your hospital. Surgeons like the new B.F.Goodrich "Surgiderm" glove because it is so much more comfortable than other surgical gloves. It is extremely sensitive to the touch, protective yet responsive to even the slightest movement of the fingers.

Comparison tests prove that the B.F.Goodrich "Surgiderm" glove is 30 to 50 per cent softer than any regular rubber surgeons' glove, including the brown cement type. Because it's softer and more pliable, it takes 25 to 30% less force to flex the fingers and hand, a tremendous factor in reducing fatigue.

In addition to comfort and sensitivity, this B.F.Goodrich glove is long lasting. It is strong to start with and stays strong even after many sterilizations. It is 36% stronger than a brown cement type glove *before* use, 67% stronger *after* ten sterilizations. What's more, it keeps its elasticity, can be stored for months with no danger of deterioration.

With this combination of comfort, strength and sensitivity, you'd expect B.F.Goodrich "Surgiderm" gloves to be expensive. Actually they cost no more than many standard gloves now on the market. They are made in sizes from 6 to 10, have rolled wrists which fit snugly over the gown, are brown in color. *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Co., Akron 18, Ohio.*

B.F.Goodrich

classified advertising

TERMS: 20c a word—minimum charge of $4.00 regardless of discounts. No charge for "key" number. Ten per cent discount for two or more insertions (after the first insertion) without changes of copy. Forms close 15th of month.

POSITIONS WANTED

ADMINISTRATOR—Top level executive, last three years hospital management consultant, partner in top firm; experienced in planning, equipping, staffing, reorganizing and operating hospitals; budget specialist. Apply MW 17, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ADMINISTRATOR—X-ray technician; male 39, 7 years experience in 40-bed general hospital; excellent record and references; able to take complete charge of small general hospital, convalescent home or clinic; desires Florida location. Write or contact Robert Hansen, 1015 16th Avenue, South Milwaukee, Wisconsin.

BUILDING OR MAINTENANCE ENGINEER—Twenty-five years experience; ten years supervisory experience dealing with construction and maintenance contractors, tradesmen, preventive maintenance programs; heavy experience in electrical, heating, and ventilation equipment; have complete working knowledge of the various trades; member of the American Institute of Electrical Engineers and National Association of Power Engineers; willing to assume complete responsibility for new start-up or existing operation; present location New York State; age 51; would relocate. Apply MW 16, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

Our 62nd Year

Telephone RAndolph 6-5682

ANESTHESIOLOGIST — Several years, private practice, anesthesiology; prefers directorship, large hospital anesthesiology department; eastern seaboard; Ohio; Connecticut; Diplomate, FACA.

PATHOLOGIST—Two years, assistant pathologist, 300-bed hospital; 2 yrs., private practice and attending pathologist, two hospitals, 600-beds, capacity; seeks directorship, hospital department; age 35; Diplomate, CP, PA.

RADIOLOGIST—Two years, assistant and instructor, radiology; important medical school; interested atomic medicine; middle 30's; any locality; Diplomate, both branches.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE, CHICAGO

ADMINISTRATOR — MEDICAL; M.P.H.; 7 years, assistant superintendent, 1200-bed general hospital; 3 years, administrative staff, one of leading organizations in medicine.

MEDICAL BUREAU—*Continued*

ADMINISTRATOR—M.H.A.; 4 years, associate director teaching hospital, assisting in building program increasing capacity from 200 to 400; 6 years, director 225-bed hospital.

ADMINISTRATOR—R.N.; degree in Hospital Administration; 16 years, director 125-bed hospital; 6 years, 275-beds; FACHA.

COMPTROLLER—B.S.; 7 years head of department, 550-bed hospital; 2 years, director department, 1000-bed hospital.

PATHOLOGIST—M.S. (Pathology); Diplomate (Pathologic Anatomy; Clinical Pathology); 8 years, director of pathology, 250-bed hospital.

PERSONNEL DIRECTOR—Master's in Psychology; in 1952 organized personnel department, 3000-bed hospital; since then has served as director of personnel.

RADIOLOGIST—Diplomate (Diagnosis, Therapy, Radium); trained in isotopes; 4 years director of department, 200-bed hospital.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—Degree; Registered X-ray technician; 4 years administrator-technician, 20-30 bed hospitals, Oklahoma, Nebraska.

ASSISTANT ADMINISTRATOR—M.S. Degree, Hospital Administration. 2 years administrative resident and assistant; available April; mid-west or west.

BUSINESS MANAGER—C. P. A; experience: accountant-consultant, mid-western hospitals, 5 years.

BUSINESS MANAGER—Controller, 500-bed eastern hospital; 5 years chief accountant, business firm.

PERSONNEL DIRECTOR—7 years supervisor, administrative staff, U.S. Army hospital; available.

EXECUTIVE HOUSEKEEPER—B.A. Degree; assistant manager, Home for Aged, 10 years; past 4 years service supervisor, eastern hospital.

DIRECTOR OF NURSING—M.A. Degree, June 1958; 4 years director, school of nursing, Illinois; prefers 175-225 bed hospital.

POSITIONS OPEN

ADMINISTRATOR — For 110-bed Southern California proprietary hospital; must be capable of being in complete charge of hospital; business background essential, salary open depending on experience and qualifications. Apply MO 219, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ANESTHETIST—Nurse; RNA for 125-bed hospital; 40 hour week; salary open. Contact G. L. Crutchfield, Administrator, Ouachita County Hospital, Camden, Arkansas.

(Continued on page 174)

ANESTHETIST—Nurse; for municipal hospital expanding to 200-beds; 4 major operating rooms, 1 minor operating room and cystoscopy room; salary open. Contact John M. Alexon, Administrator, Virginia Municipal Hospital, Virginia, Minnesota.

ANESTHETIST—Nurse; female; good salary, liberal fringe benefits; good hours; accredited 58-bed hospital. Apply to Superintendent of Allen Memorial Hospital, Oberlin College, Oberlin, Ohio.

ANESTHETIST—Nurse; for 200-bed hospital, staffed with 5 nurse anesthetists. Contact T. W. Patterson, Administrator, Herbert J. Thomas Memorial Hospital, South Charleston 3, West Virginia.

ANESTHETIST—Nurse; 60-bed general hospital, new building, modern equipment; western Wisconsin, college town, vacation, sick leave, retirement plan. Apply to H. C. Guntner, Manager, Memorial Hospital, Menominee, Wisconsin.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 N. Maryland Avenue, Milwaukee 11, Wis.

DENTAL HYGIENIST—Must have completed a course in dental hygiene at a recognized school, college, or university; salary range $3360-$3960, liberal employee benefits. Apply Personnel Director Ancora State Hospital, Hammonton, New Jersey.

DIETITIAN—Must be A.D.A. member; 90-bed enlarging to 130-beds with school of nursing good personnel policies; 40-hour week; hospital fully approved by J.C.H.A.; salary open. Apply MO 216, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

DIETITIAN—ADA; 125-bed hospital; 40 hour week; salary open; to replace retiring dietitian. Contact G. L. Crutchfield, Administrator, Ouachita County Hospital, Camden, Arkansas.

DIETITIAN—For Southern California county hospital near desert, mountains, and seashore; $4,218-$5,004; college graduation, year's internship, and ADA membership required; paid vacation and sick leave, part-paid health insurance, other benefits. Apply County Personnel, 236—3rd Street, San Bernardino, California.

DIETITIAN—Excellent opportunity for ADA registered, hospital-trained person in therapeutic or administrative dietetics; salary commensurate with training and experience; chances for promotion excellent; liberal benefits. Apply Personnel Director, Iowa Methodist Hospital, Des Moines, Iowa.

DIETITIAN—Therapeutic; Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

DIETITIAN—College graduate, salary range $3870-$4740, forty-hour week, liberal employee benefits. Apply Personnel Director, Ancora State Hospital, Hammonton, New Jersey.

classified advertising

POSITIONS OPEN

DIETITIANS—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—A.D.A. or equal; full charge of department in 55-bed general hospital, modern kitchen, excellent conditions, salary open. Apply Administrator, Lakeview Memorial Hospital, Bath, New York.

DIETITIAN—Prefer A.D.A. member; both administrative and therapeutic work; modern all electric air-conditioned kitchen. For information write Harriette S. Oeftiger, Personnel Director, Wilson Memorial Hospital, Johnson City, New York.

DIETITIAN—Chief; top level position, excellent opportunity; modern 230-bed hospital expanding to 320; applicant must have administrative experience; salary open. Send full details and photograph to Superintendent, Bethesda Hospital, Oak Street and Reading Road, Cincinnati 6, Ohio.

DIETITIANS—(a) Supervisor for new cafeteria (b) assistant therapeutic; 40 hour week; two, three or four weeks vacation depending upon length of service; liberal sick leave; wide range of salaries; two 350-bed private general hospitals. Apply Director of Dietetics, Youngstown Hospital Association, Youngstown, Ohio.

DIETITIANS—All levels, for large center-city hospital; salary open. Write, giving experience, to Personnel Director, Jefferson Hospital, 10th & Sansom Streets, Philadelphia 7, Pennsylvania.

DIRECTOR OF NURSES—B.S. degree in Nursing Education and experience or Masters Degree; salary open, 40-hour week, good personnel policies; hospital fully approved by J.C.H.A. Apply MO 215, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING SERVICE—Expanding 300-bed West Coast hospital, metropolitan location; salary open; desire candidate with 2 years demonstrated progressive administrative experience plus MA in Nursing Administration, or 6 years comparable experience. Write MO 218, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ASSISTANT DIRECTOR OF NURSING—Service and education; large midwestern hospital in pleasant suburban area; furnished apartment available; near excellent shopping facilities and transportation; paid vacation, sick leave and retirement plan. Send resume of experience and training to MO 220, The Modern Hospital, 919 N. Michigan Ave., Chicago 11, Illinois.

DIRECTOR OF NURSES—100-bed J.C.A.H. approved, general hospital with 3 year diploma school of nursing; east; expansion program in process; good working conditions, social security and group hospitalization; position open July 1, 1958; Degree required; salary open. Apply MO 221, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING — R.N.; supervise nursing functions of 220-bed modern home for aged opened in 1953; full maintenance, vacation and sick leave; social security and Illinois Municipal Retirement Plan; located near Moline, Illinois. Write with resume of experience to Business Manager, Oak Glen Home, Coal Valley, Illinois.

DIRECTOR OF NURSES—Immediate opening in small, completely modern hospital expanding to 30-beds, new wing to open March 1, 1958 with latest equipment and facilities; will consider general duty R.N. wishing to advance; must have knowledge of surgical procedures; salary open, vacation, sick leave. Apply to Administrator, Ness County Hospital, Ness City, Kansas.

DIRECTOR OF NURSING SERVICE—Active 100-bed community hospital at county seat in beautiful Kittatinny Mountains, 1½ hours from New York City; liberal salary contingent upon qualifications, living accommodations available. Contact L. S. Hartford, Administrator, Newton Memorial Hospital, Newton, New Jersey.

DIRECTOR OF NURSING—If you are looking for a challenging opportunity we would like to hear from you; we are a 92-bed general community hospital serving a densely populated area, located in northeast Cleveland, 40-hour week, social security, liberal vacation. Write, giving full particulars on experience to J. C. Gliemmo, Director, Forest City Hospital, 701 Parkwood Drive, Cleveland 8, Ohio.

DIRECTOR OF NURSING SERVICE—300-bed Catholic general hospital; NLN accredited school of nursing; must have BS degree in nursing service, but a Master's preferable; though open the salary meets the OSNA minimum standards. Apply Personnel Director, Providence Hospital, 700 N. E. 47 Avenue, Portland 13, Oregon.

DIRECTOR—NURSING SERVICE AND EDUCATION—300-bed Protestant general hospital, expansion program in progress, with 150-student School of Nursing, needs director of nursing to be responsible for nursing service and school of nursing; applicants should be in excellent health, between approximate ages of 35-45; liberal salary range and benefits; excellent working conditions in one of the midwest's foremost institutions, centrally located in the city and convenient to outstanding residential and shopping facilities. Contact Mr. S. W. Martin, Administrator, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

NURSING INSTRUCTOR—Positions as nursing instructor I are available in both the Los Angeles County General Hospital nursing service and in our school of nursing; appointees to these positions will assist in the improvement of patient care by planning and executing an organized educational program for nursing service personnel or students in specific clinic areas; present salary range for this position is $440-$545; the requirements are: college graduation with 12 units in education and graduation from an accredited nursing school plus either 6 months of teaching experience in an accredited nursing school or 1 year supervisory nursing or completion of a curriculum in clinical instruction. Our school of nursing is one of the largest accredited schools of nursing in the west; it is a diploma school (36 month course) and is fully approved by the Accreditation Service of the National League for Nursing; faculty positions are available in medical, surgical or obstetrical services; nursing service positions are available in the following areas: pediatrics and communicable diseases, psychiatry, EENT, placement and jail service; won't you join us in the development of modern progressive teaching hospital. Please write me for full information. Betty Hartwig, Los Angeles County General Hospital, Box 1311, North State Street, Los Angeles 33.

(Continued on page 176)

INSTRUCTOR—Obstetric clinical; diploma school, temporary NLN accreditation; 250-bed private hospital; B.S. and experience required; salary dependent on preparation. Reply MO 222, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

INSTRUCTOR—Nursing arts; diploma school, 180-bed general hospital; B.S. Degree required, many benefits; 6 blocks from heart of University of Illinois. Apply Director of Nurses, Julia F. Burnham School of Nursing, Champaign, Illinois

INSTRUCTORS—Clinical; for operating room technique and in medical and surgical nursing, day, evening and night shifts; integrated program; affiliated with Drake University; 200 students in school; 400-bed, fully approved, non-profit hospital; minimum qualifications: B.S. degree, preferably in nursing education; salary open, 40 hour work week; 20 working days vacation; sick benefits; position open immediately. Apply Director of Nursing, Iowa Methodist Hospital, Des Moines, Iowa.

INSTRUCTORS — Clinical; medical and surgical nursing, nursing of children and obstetric nursing for diploma program with 50 students; very good personnel policies and congenial working conditions; academic preparation and/or experience desirable; salary commensurate with preparation and experience. Write Director, School of Nursing, St. Joseph's Hospital, St. Joseph, Missouri.

INSTRUCTOR OF NURSES—B.S. Nursing Education, salary range $4560-$5460; new nurses' home, liberal employee benefits. Apply Personnel Director, Ancora State Hospital, Hammonton, New Jersey.

INSTRUCTOR—Clinical; medical-surgical formal and clinical teaching in NLN temporary accredited diploma program; integrated course correlated with other courses over a 39-week period during the first year; no service responsibilities, permissive atmosphere for joint planning and function; B.S. degree required; liberal personnel policies, salary commensurate with experience and preparation. Apply to Director, School of Nursing, Memorial Hospital, Pawtucket, Rhode Island.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Medical record; assume charge records department; 58-bed cancer hospital; cancer registry; standard nomenclature, statistical reports; salary open. Write Miss F. C. Martin, Oncologic Hospital, 33rd & Powelton Avenue, Philadelphia 4, Pa.

MEDICAL DIRECTOR — Assistant; 114-bed tuberculosis hospital, salary $8500-$9500 per year plus complete maintenance including apartment, food, laundry, and utilities. Apply Executive Director, State Tuberculosis Commission, New Capitol Annex, Frankfort, Kentucky.

MISCELLANEOUS—Openings for Anesthetist and two Registered Nurses for supervision; 38-bed general hospital; salary open, good personnel policies. Contact Superintendent Red Wing City Hospital, Red Wing, Minn.

NURSING—Staff; annually $3000 to $3360 plus two meals daily and uniform laundry, six paid holidays, liberal sick leave and vacation. Apply Director of Nursing, Episcopal Eye, Ear and Throat Hospital, 1147 15th St., N.W., Washington 5, D.C.

Ultra-modern Main Kitchen at St. Elizabeth's Hospital in Belleville, Illinois. Architect Henry R. Slaby of Milwaukee, Wisconsin, specified interiors of Natco Ceramic Glaze Vitritile and exteriors of Natco Buff Roman Face Brick. Contractor was Bauer Brothers Construction Company of Belleville.

St. Elizabeth's Hospital—where Corridors, Laundry, Kitchens, Power Plant, Laboratories, Wash Rooms, Lockers and Food Storage Rooms, Cafeteria—even the Chapel *have an always new look, thanks to NATCO Ceramic Glaze Vitritile*

St. Elizabeth's Hospital at Belleville, Illinois, presents a striking example of the use of two major products. The exterior walls are Natco Buff Roman Face Brick while interiors feature Natco Ceramic Glaze Vitritile combining permanence and beauty in a wide range of locations.

Builders find Natco Ceramic Glaze Vitritile also offers other important features in a single building material. It makes sound, fire-proof structural walls and partitions, plus a colorful wear-resistant interior finish in a single operation . . . at one cost. Years after installation it will retain its new look because soap and water maintenance is all it ever needs.

Finally, Natco Vitritile is available in 21 standard colors (including the new speckled glaze) to permit selection of the shade needed for pleasing appearance and proper lighting.

SIZES AND SHAPES

Series	Nominal Face Size	Tile Face Size	Nominal Thickness
"8W"	8" x 16"	7¾" x 15¾"	2", 4"
"6T"	5⅓" x 12"	5⅛" x 11¾"	2", 4", 6", 8"
"4D"	5⅓" x 8"	5⅛" x 7¾"	2", 4", 6", 8"

NATCO
CORPORATION

GENERAL OFFICES: 327 Fifth Avenue, Pittsburgh 22, Pa.
BRANCH SALES OFFICES: Boston • Chicago • Detroit • New York • Philadelphia • Pittsburgh • Syracuse • Birmingham, Alabama • Brazil, Indiana
IN CANADA: Natco Clay Products Ltd., Toronto

classified advertising

POSITIONS OPEN

NURSE—Registered; 34-bed modern hospital in southwestern Colorado approximately 4500 population, 40-hour week, 2 weeks paid vacation, 12 days paid accumulative sick leave, 4 paid holidays, social security benefits, semi-annual raises, Blue Cross and Blue Shield, optional meals and laundry furnished; substantial differential for night duty; starting salary $310 per month. Contact Administrator, Community Hospital, Monte Vista, Colorado.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—Staff; staff positions in all clinical areas including psychiatry, poliomyelitis and respiratory center in new, 800-bed air conditioned hospital; 40-hour week; 3 weeks vacation annually; beginning salary; staff nurses, $275 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSES—Registered; general duty, 180-bed general hospital; 6 blocks from heart of University of Illinois; starting salary $230, differential for p.m. and night duty, 40 hour week, no rotating shifts, 7 holidays, sick leave, vacation, Blue Cross and Blue Shield. Apply Acting Director Nursing Service, Burnham City Hospital, Champaign, Illinois.

NURSE—Registered; proven administrative ability for nursing home; this is not just a position; future security, paying substantial salary when qualifications have been demonstrated; age range 35-50 years. Call LIberty 9-1265 between 9:30 A.M. and 4:30 P.M. daily. Middlesex Nursing Home, Metuchen, New Jersey.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for supervising psychiatric buildings and atttendants; mature experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

PHYSICAL THERAPIST—Male or female; for new department in 225-bed general hospital; salary open, personnel policies excellent; Contact Administrator, Allen Memorial Hospital Waterloo, Iowa.

SUPERINTENDENT OF NURSES—Registered nurse; for new 34-bed County Hospital; salary starts at $300 per month with automatic raise to $325 after 6 months; prefer single woman between ages of 40 and 55 years; apartment in hospital and meals furnished; ability to perform as surgical nurse desirable but not required. Write Administrator Wayne County Hospital, Corydon, Iowa.

SUPERVISOR—Clinical instructor; for 22-bed, open ward, new psychiatric unit; NLN accredited; degree or post course, teaching experience desired; salary open. Apply Nurse Administrator, Northwest Texas Hospital, Amarillo, Texas.

SUPERVISOR — Pediatric teaching; 37-bed pediatric ward, 250-bed hospital, full NLN accreditation, JACH; degree and experience preferred; liberal personnel policies; salary open. Apply Nurse Administrator, Northwest Texas Hospital, Amarillo, Texas.

TECHNOLOGIST—Laboratory; 250-bed hospital; salary open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

TECHNICIAN—Laboratory; 40 hour week. Write Personnel Office, Holy Cross Hospital Inc., 4701 N. Federal Highway, Fort Lauderdale, Florida.

TECHNICIAN — Laboratory; 236-bed general hospital 30 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

TECHNICIAN — Chief laboratory; Brightlook Hospital, 10 Summer Street, St. Johnsbury, Vermont; 52-bed accredited general hospital; laboratory under supervision of pathologist; salary $400 per month if well qualified. Write or telephone Ralph H. Ross, Acting Administrator, PIoneer 8-2311.

TECHNICIAN—Needed June first; combined laboratory and x-ray technician for small hospital, moderately busy. For particulars contact St. Ann's Hospital, Juneau, Alaska.

TECHNOLOGISTS—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Consultant; important medical educational program; preferably one experienced in graduate field; some travel. (b) Assistant medical director, 450-bed general hospital; duties include directing resident program; interesting city outside U.S.; (c) Director, 400-bed general hospital affiliated with medical school; south; (d) Director, new community hospital, 300-beds; now in planning stage; highly qualified man, medical or lay; university city, east; (e) Director; hospital now under construction, 54 acute—20 nursing; completion 15 months, California; $750, increase upon completion. (f) Assistant director; large teaching hospital, principal hospital university group; experience in large facility desired; Pacific Coast. (g) Assistant administrator, 300-bed general hospital; medical school affiliated; important medical center, southwest. (h) Assistant; 200-bed general hospital; preferably course graduate with some experience; university city, east. (i) R.N., graduate of hospital course to assist administrator, 400-bed hospital; large city, middle west. MH3-1

ANESTHETISTS—(a) Free lance; replace M.D.; beautiful Ozarks region; (b) OB, 250-bed hospital, near Chicago; $6600; (c) To join 16 man clinic near university city, Ohio; $6000 up; (d) Anesthetist-Director of Nurses; small air-conditioned hospital; college town near Houston; top salary. MH3-2

DIETITIANS—(a) Chief, 500-bed university teaching hospital, staff includes 10 dietitians; to $6700; south, (b) Chief; 125-bed hospital, commuting distance New York City; excellent salary. MH3-3

DIRECTORS OF NURSES—(a) Director of Nurses; all graduate staff; for progressive program of expanding 300 bed hospital; West Coast university city; good salary potential; (b) Dir. Nursing Service School; well-established 400-bed hospital; 120 students; N.Y.; $7500 up (c) Act as nursing representative, nat'l. organization Atlantic, Pacific Coast; $6000, travel expenses; (d) Overseas; administer in-patient wards of Central Nursing Office; internationally reputable industrial organization; $10,200; paid air travel; Master's, Nursing Administration required. MH3-4

EXECUTIVE PERSONNEL—(a) Comptroller; voluntary general hospital, 300-beds; college graduate with 5 years' experience required; east; $10,000. (b) Food manager, 275-bed hospital, complete charge of department; $600; southwest; university, resort city. (c) Personnel director, well organized program; teaching hospital, 1000-beds; $9000-$10,000. (d) Clinic manager; 5-man group; expansion program; southwest. MH3-5

EXECUTIVE HOUSEKEEPERS — (a) Take charge of maintenance 250-bed hospital, nurses' residence, physicians' office building; unlimited opportunity for experienced male; near Chicago. (b) 110-bed hospital, wealthy Texas oil center, top salary. MH3-6

FACULTY POSTS—(a) Educational Director.; unusual opportunity established affiliation in psychiatry research hospital; university medical school association; top salary; east; (b) Pediatric; basic college nursing program; Greater Manhattan; faculty appointment. (c) Overseas; Director of School; university college of nursing; English speaking students from 23 countries; mild climate; paid transportation; also Nursing Arts Instructor; (d) Assistant Professor, Mental Hygiene; university appointment; $6500; Ohio. MH3-7

MEDICAL RECORD LIBRARIANS — (a) Chief, manage department of 13; latest record equipment; top salary for qualified person; hospital opened 1956; middle west industrial center; (b) Recent graduate considered, chief, 160-bed hospital near Cape Cod; outstanding facility; supervise 3; cooperate records committee; $4200-$5000. MH 3-8

SUPERVISORS—(a) OR with pg.; suite of 7 air-conditioned rooms; 220 bed hospital; near North West college center; $6000; (b) To become assistant director service; well renowned university hospital, Texas; salary commensurate experience; (c) Psychiatric supervisor specialized research hospital; exceptional opportunity advancement; $5000 up.; east; (d) Manage convalescent home, 50 patients; beautiful Chicago suburb; $5000 up, maintenance. MH 3-9

(Continued facing page 177)

To make a patient feel like a king ...this *Theme* room by Simmons

Here's the kind of room that can give a big boost to a patient's morale—and to the prestige of your hospital. With its warm, friendly *Theme* furniture, it looks like a luxurious guest room. And it fosters patient-hospital relations because it makes important patients glad to recommend your hospital.

But let's be practical, too. The mellow-grained *Sable* Textolite on all case and table tops, as well as on drawer fronts, resists damage from scratches or spilled liquids. The sturdiness of steel defies long years of hospital use—requires the very minimum of upkeep.

And the motorized Vari-Hite bed itself is a marvel of effortless operation, thanks to the efficient motor that raises or lowers bed height at the touch of a finger. Naturally, it's approved by the Underwriters' Laboratories and is equipped with the famous Hospital Beautyrest* mattress.

* * *

Theme unit furniture, designed by Raymond Spilman, S. I. D., allows you to design furniture to fit every patient room or public seating area. Your Simmons agent or nearby Simmons office is always ready with advice based on nationwide hospital experience.

SIMMONS COMPANY

DISPLAY ROOMS:
Chicago • New York • San Francisco
Atlanta • Dallas • Columbus • Los Angeles

*Trade Mark Reg. U.S. Patent Office

classified advertising

POSITIONS OPEN

Our 62nd Year

WOODWARD
Medical Personnel Bureau
FORMERLY AZNOE'S
3rd floor • 185 N. WABASH AVE.
CHICAGO • 1
• ANN WOODWARD • *Director*

Telephone: RAndolph 6-5682

ADMINISTRATORS — (a) 100-bed, general, voluntary hospital; small town, Pennsylvania. (b) Children's medical center; two units composed of child-guidance and mental training; university city; southwest. (c) New, smaller, private-community hospital, opened Fall '57; small town, large drawing area, rapidly expanding, California. (d) 450-bed fully-approved hospital, now increasing size; $15,000, increase 6 months; home and utilities; east. (e) New hospital, 70-beds; psychiatric service; $6,000; university medical school city, midwest. (f) 350-bed, fully approved hospital; outstanding board and staff; must be affiliated ACHA; minimum $20,000. (g) JCAH, 60-bed hospital increasing to 100-beds; about $12,000; northeast. (h) 40-bed, fully equipped and modern retirement home; $6,000, possibility of maintenance; near Gulf of Mexico; (i) Medical Director with administrative experience and executive ability; 500-bed, JCAH hosp.; teaching program; attractive college town, 150,000; east.

WOODWARD—*Continued*

ASSISTANT ADMINISTRATORS — (j) Voluntary, general hospital; fairly large size; large town, vicinity Detroit. (k) Assistant short time, then associate director; children's hospital, 200-beds; will succeed present director upon retirement; university city; West Mountains. (l) 165-bed, TB unit of 800-bed hospital system; opportunity for advancement within system; town 300,000, California. (m) 160-bed hospital, city-operated; town 40,000; Deep south. (n) Medical; 100-bed, TB sanatorium; diagnosis and treatment of all forms of TB; active research program; teaching affiliation with Mayo foundation; salary and furnished home.

ADMINISTRATIVE POSTS — (o) Business Manager; important children's center; requires experienced administrator; to $15,000; east. (p) Business manager with Accounting degree; advancement to comptroller, assistant administrator; large, fully approved hospital; central. (q) Clinic manager to replace one nearing retirement age; long established 20 man group; own building; excellent equipment; fine policies; northwest central.

(Continued on page 178)

MEDICAL EMPLOYMENT SERVICE
59 East Madison Chicago 2, Ill.
ANdover 3-5663-64
Alfred E. Riley, R.N., MSHA Director

ADMINISTRATORS — (a) 120-bed hospital, east; salary $10,000. (b) 125-bed hospital, south; salary open; new hospital. (c) 50-bed hospital, Iowa; salary open. (d) 50-bed hospital, Missouri; salary open. (e) 75-bed hospital; New England; salary open. (f) 60-bed hospital, Wyoming; salary open.

ASSISTANT ADMINISTRATORS — (a) 400-bed hospital, south; to handle purchasing; salary $500. (b) 300-bed hospital, Ohio; to handle personnel; salary $500. (c) 200-bed hospital, midwest; must handle business office and accounting; salary $600. (d) 120-bed hospital, Florida; to handle business management; $350. (e) Large State Hospital; to handle personnel; salary $450.

BUSINESS MANAGERS — (a) 300-bed midwest hospital; seeking a top business manager to reorganize and install machine accounting in this hospital; must have at least BS degree in Business Administration and five years' experience; salary open.

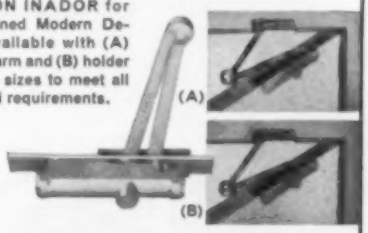
PHARMACIST — (a) Chief pharmacist for large Sisters Hospital, Florida; salary $600 per month. (b) Assistant pharmacist, Chicago; salary $475.

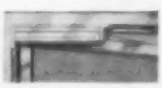
JOHN E. BRINK, A.I.A.—STATE ARCHITECT

New Kansas State Office Building Joins the Distinguished Roster of Norton Inador® Users

Complete Norton Line Meets Every Door Closer Need

NORTON INADOR for Streamlined Modern Design Available with (A) regular arm and (B) holder arm...4 sizes to meet all standard requirements.





NORTON 750: New corner design with concealed arms for all type doors, particularly narrow rail doors.

Norton Surface-type Closers are available for all installations where concealment is not essential.

NORTON 703E: Compact surface mounted type...first closer with extruded aluminum alloy shell.

An interior to match the dramatic simplicity of this imposing exterior called for painstaking attention to every detail, including door closers. The *Norton Inador* Closer was selected because it is so nearly invisible. Its compact mechanism being entirely concealed in a mortise in the top rail of the door, there is nothing to detract from the beauty of the door itself.

There is also no sacrifice of efficiency. Every *Norton Inador* is designed and built to last longer...require less maintenance and provide the long-range economies imperative in all public buildings. If, therefore, you now have such a building "on the boards," investigate *Norton Inador* while door closer specifications are still undecided. Write today for FREE copy of the new catalog on Norton's full line of concealed and surface door closers including important new models.

FOR ADDITIONAL MODELS, CONSULT NEW #57 CATALOG

NORTON DOOR CLOSERS

Dept. MH38 • Berrien Springs, Michigan

classified advertising

POSITIONS OPEN

MEDICAL EMPLOYMENT—*Continued*

EXECUTIVE HOUSEKEEPERS — (a) Chicago; for 125-bed hospital; salary $350 plus 2½ room apartment; meals and laundry. (b) 200-bed hospital, east; salary $400. (c) 100-bed hospital, West Virginia; salary $350. (d) 150-bed hospital, Iowa; salary open.

FOOD SERVICE MANAGERS—(a) 125-bed hospital, Chicago; salary $500. (b) 200-bed hospital, Texas; salary $500. (c) 200-bed hospital, Utah; salary open.

LABORATORY TECHNICIAN — (a) Bio-Chemist; Chicago; large teaching hospital; research in hematology; salary $550. (b) Bio-Chemist; California; research; salary open. (c) Bacteriologist; BS or MS level; salary open. (d) ASCP; laboratory technician, male or female, midwest; near Chicago; salary $500.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR — (a) 125-bed hospital, Ohio. (b) 75-bed West Virginia hospital. (c) 35-bed hospital, Michigan; Minnesota. (d) R.N; 30-bed hospital, Iowa.

PURCHASING AGENT—(a) 300-bed hospital, Pennsylvania. (b) 275-bed hospital, southwest.

CONTROLLER—(a) 400-bed hospital, east. (b) 300-bed hospital, Pennsylvania. (c) 200-bed hospital, southeast. (d) 200-bed hospital, Michigan.

DIRECTORS OF NURSING—125-bed hospitals, Virginia, Delaware, Ohio, Georgia, Pennsylvania; to $6500.

DIRECTORS, NURSING EDUCATION—$6-$7200.

TECHNICIANS—(a) Biochemistry; to $7,500. (b) Supervisor, Hematology; $4,500. (c) Laboratory; X-ray; 81-bed hospital, mid-west.

EXECUTIVE HOUSEKEEPER—(a) 200-bed hospital, Maryland. (b) 350-bed Ohio hospital. (c) 250-bed Indiana hospital. (d) Assistant 600-bed hospital, east.

MEDICAL RECORD LIBRARIANS—To $6,000.

(Continued on page 180)

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

EXECUTIVE PERSONNEL—(a) Controller; California; 200-bed hospital near San Francisco; $7200. (b) Credit manager; south; 200-bed hospital; 13 in department; $5000 up. (c) Personnel director; south; 375-bed hospital in city of 70,000. (d) Assistant administrator; 375-bed hospital near Washington, D.C.; $6500 to start. (e) Business manager; northwest; group of 17 specialists; excellent opportunity. (f) Credit and collection manager; east; college degree preferred but not essential; 400-bed hospital; $5500. (g) Controller; Southwest; 350-bed hospital; good background in accounting; to $10,000. (h) Statistician; world famous university conducting research on effects of housing quality on physical health, mental health, and social adjustment; will be given faculty appointment if qualified; $6200.

DIETITIANS—(a) Chief; 200-bed hospital; middle west; expanding dietary department; to $7500. (b) South; chief; 200-bed hospital, some teaching, $5400. (c) South; chief; set up department in new 300-bed hospital; $6000.

Bolta Floor®

(SOLID VINYL FLOORING)

rugged, non-porous resists soil and wear

Beautiful, resilient Bolta-Floor is the perfect flooring for busy hospital corridors, reception areas and patient's rooms. It cushions noise from wheeled equipment and footsteps . . . resists scuffs and stains . . . won't crack, chip or shrink. Bolta-Floor remains unharmed by water and detergents . . . keeps its rich lustrous beauty years longer.

GENERAL PLASTICS
The General Tire & Rubber Company

THE GENERAL TIRE & RUBBER COMPANY
BOLTA-FLOOR DIVISION • AKRON 9, OHIO

SPECIFICATIONS: Bolta-Floor is available in 23 marbleized, 24 "Terrazzo" and 5 solid colors, in standard 9" x 9", or special orders of 6" x 6", 12" x 12", or 18" x 18" tiles in .080" and ⅛" gauges. Solid and marbleized are also offered in ½" gauge and in 27", 45" and 54" roll widths for floors, walls and countertops. See Sweet's 13i/Ge.

classified advertising

POSITIONS OPEN

SHAY—*Continued*

SOCIAL SERVICE—(a) Chief; psychiatric; M.S. degree; large eastern mental hospital; $7800 plus house and utilities. (b) Supervise mental health center in city of 200,000; $5400 minimum. (c) Psychiatric; south; Guidance Center for children and adults serving area of about 120,000. $6900.

MEDICAL RECORD LIBRARIANS — (a) Chief; Midwest 125-bed hospital opened in 1953; near Chicago; $5400. (b) South; take charge of department in large hospital near Washington, D.C.; 9 employees; $5300. (c) Chief; east 150-bed hospital 5 employees in department; city of 50,000; $5000 minimum.

PLACEMENT BUREAUS

INDIANA MEDICAL BUREAU
212 Bankers Trust Bldg.
Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

PLACEMENT BUREAUS

Specialists for private duty placement in Hospitals and Homes.

655 Sutter Street

San Francisco

Gr-4-7005

A-1 NURSES REGISTRY

6087 Sunset Blvd.

Los Angeles

Ho. 2-7293

Cr. 4-7255

Po. 3-7269

We invite inquiries.

A licensed and bonded Professional Nurses Agency.

(Continued on page 182)

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES

11 West 42 Street New York 36, N.Y.

Mary A. Johnson, Ph.D., Director

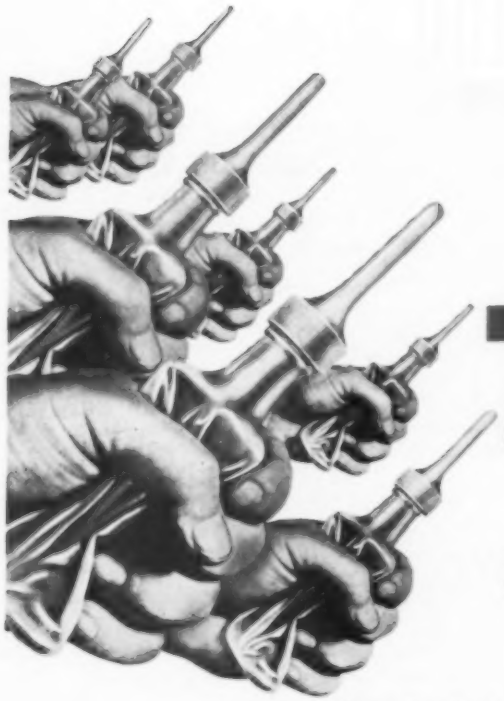
FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven methods shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Agency



7 FLEET® ENEMA

Disposable Units *

may be administered in the time required for 1 soap suds enema.[1]

administrators like *FEDU

because FLEET ENEMA Disposable Units save time and money.[1]

physicians like *FEDU

because the 4½ fl. oz. unit is more effective than one or two pints of soap suds,[2] and the anatomically correct rectal tube minimizes injury hazard.[3]

personnel like *FEDU

because FLEET ENEMA Disposable Unit is ready to use, even to the pre-lubricated rectal tube. Eliminates preparation and "clean-up."

and patients like *FEDU

because FLEET ENEMA's combination of 16 Gm. Sodium Biphosphate and 6 Gm. Sodium Phosphate is gentle and the small amount of solution seldom causes pain or griping.

1. "Standard vs Disposable Unit Enema": Rainier, W. G.: and Lee, B., Hospitals 31:50, Jan. 1, 1957
2. Swinton, N. W., Surg. Clinics No. Am. 35:833, 1955
3. Palmer, E. D., "Clinical Enterology," Hoeber-Harper, 1957

and now **OIL RETENTION ENEMA** (FLEET)*

each single use disposable unit contains 127 cc. Mineral Oil USP.

Write for free copy of Rainier-Lee Time-Cost Study, Samples and Price List

since 1869 Fleet

C. B. FLEET CO., INC., Lynchburg, Virginia

makers of Phospho-Soda (FLEET)

In Canada: Produced by Charles E. Frosst & Company

classified advertising

PLACEMENT BUREAUS

DOROTHEA BOWLBY ASSOCIATES
8 South Michigan Avenue Chicago 3, Ill.
Suite 618—ANdover 3-5293
Dorothea Bowlby, Director

A Specialized Employment Service for Medical and Hospital Personnel. (Men and Women.) For Administrators, Personnel Directors, Business Managers, Dietitians, Physicians, Directors of Nurses, Therapists, Pharmacists, Medical Record Librarians, Anesthetists, Public Relations Directors, Housekeepers, Bacteriologists, Biochemists, Medical Technologists, X-Ray Technicians, Food Service Managers. All inquiries from applicants are kept strictly confidential.

FOR SALE

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS
400 East 59th Street, New York City

FOR SALE

NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

NURSING HOME—There are more than 40 rooms in this operation which will accommodate between 50 to 60 patients, and for the last 10 years since the owner acquired the property, it has operated at full capacity. Located in small town 30 miles from Louisville, Ky., easily accessible by two excellent highways, buses and trains. At the owner's present reasonable rates the business nets between $25,000 and $30,000 per year. Picturesque setting with 40 acres of ground. For photo of property and complete information, write or call Harry K. Moore Co. 363 Starks Bldg., Louisville, Ky. Tel: JU 7-6641.

(Continued on page 184)

MISCELLANEOUS

WANTED TO BUY

No. 23602 large filter stones and No. 23614 small filter stones, both with sets of gaskets for use on American Sterilizer Co. Water Sterilizers. Also control valve with off, exhaust, steril and vacuum positions for a 1923 American Sterilizer Co. Autoclave. Physicians Hospital, Plattsburgh, New York.

SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

Now...easier requisitioning, less writing, faster hospital reports!

New Keysort Data Punch imprints, punches patient records in a single operation

Located at each nursing station, the new, designed-for-hospitals Keysort Data Punch frees valuable nursing personnel from bothersome writing. Simultaneously *imprints* patient information and *code-punches* statistical categories (such as nursing station or clinic, accommodation, professional service, class of payment and name or room number) onto easily-sorted Keysort Requisition-Charge Ticket sets. Far faster, more legible than handwritten records. Keysort Data Punch speeds requisitions to both service departments and business office . . . ensures fast, accurate, more complete analysis of income and service-department output. Quiet, compact, mechanically foolproof.

Learn how Keysort Data Punch—in conjunction with Keysort Requisition-Charge Tickets—can speed timely reports to your desk . . . give you the kind of administrative controls which make possible better patient care. The nearby McBee man will be glad to demonstrate the Data Punch's exclusive advantages. Phone him, or send coupon for illustrated folder.

McBEE

KEYSORT DATA PUNCH

ROYAL McBEE Corporation

Port Chester, N. Y.

In Canada: The McBee Co., Ltd., Toronto 16

To: Keysort Data Punch MH
Royal McBee Corp., Port Chester, N. Y.
Please send me complete information on the Keysort Data Punch.

*Name*_____

*Title*_____

*Hospital*_____

*City*_____

*No. of Beds*_____

classified advertising

SCHOOLS—SPECIAL INSTRUCTION

The BOSTON LYING-IN HOSPITAL offers to qualified registered nurses a six-months internship in maternity nursing. Clinical experience is offered in all phases. This includes antepartal clinics, delivery room, postpartum and diabetic unit, normal newborn, and premature nursery. Each nurse intern will have the opportunity to deliver a mother under supervision. An elective period will be spent in advanced experience in the area of choice. Room, laundry, food allowance and a stipend of $75 per month is granted. Rooms are provided in a graduated house. The registration fee is $20. For complete information write to Carolyn Davies, R.N., Director of Nurses, Boston Lying-in Hospital, Boston, Massachusetts.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital. 600 S. Kingshighway, St. Louis, Missouri.

SCHOOLS—SPECIAL INSTRUCTION

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all technique in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

SCHOOLS—SPECIAL INSTRUCTION

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

TOO LATE TO CLASSIFY

POSITIONS OPEN

STAFF DIETITIANS—One teaching; one therapeutic; A.D.A. members, hospital recently expanded to 450-beds, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air conditioned; dietetic program integrated with N.L.N. approved school of nursing, affiliated with Medical Research Institute 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

DIETITIAN—A.D.A. or equal; full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

DIETITIAN—Position to be open as head of department in May; this is a challenging opportunity to assume full responsibility in a new 92-bed general hospital; must have had administrative experience at least as an assistant; starting salary $4,500; 40 hour week; liberal vacation policy, sick leave allowed, social security. Apply Hospital Director, Forest City Hospital, 701 Parkwood Drive, Cleveland 8, Ohio.

LIBRARIAN—Registered or equal; full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

TECHNICIAN—Laboratory; with knowledge of X-ray; new 40-bed hospital. Contact Mrs. Arrabella Olson, RN, Warren Hospital, Warren, Minnesota.


INTRODUCING...
TOMAC
A dynamic concept of automatic instrument and glassware cleaning – particularly well suited for the most rigid hospital and laboratory standards.

your new servant from the world of silent sound!

Tomac Ultrasonic Cleaning Equipment

now you can ... **save over 80% cleaning labor**
... **cut costly handling and breakage**
... **use the most thorough cleaning possible**
... **enjoy simple and foolproof automaticity**

The NEW Tomac B Ultrasonic Cleaner is the fastest, most effective cleaning technique available. Ultrasonics is the conversion of sound wave energy into a form that creates a new kind of POWER. By sending high frequency sound waves, pitched so high they can never be heard, into a tank of water mixed with detergent, many millions of tiny power-packed cleaning forces are activated.

As these highly energized "bubbles" attack the soiled surfaces of instruments and glassware, the adhering grease, dried blood and other contaminants are blasted off. Any object immersed in the liquid is scrubbed CLEAN — even in the hard-to-reach places where thorough cleaning is impossible by other methods.

As a result of years of testing and "in-use" experience, there are many advantages Tomac Ultrasonic Cleaning Equipment holds for your institution. There is unbelievable new economy. A job that formerly required 45 minutes of hand scrubbing can now be done in 7½ minutes of personnel time — *a labor saving of over 80%*. Only Tomac Ultrasonic Cleaning Equipment is designed for completely automatic PUSH-BUTTON washing and rinsing. 75 to 100 instruments can be ultrasonically cleaned in a single load and even the most costly instruments are completely safe. Costly breakage from handling and hand scrubbing can be forgotten.

Tomac Ultrasonic Cleaning Equipment Booklet.
Ask your American representative for this non-technical, easy-to-understand, illustrated booklet — "Your New Servant From the World of Silent Sound," or write for your free copy today!

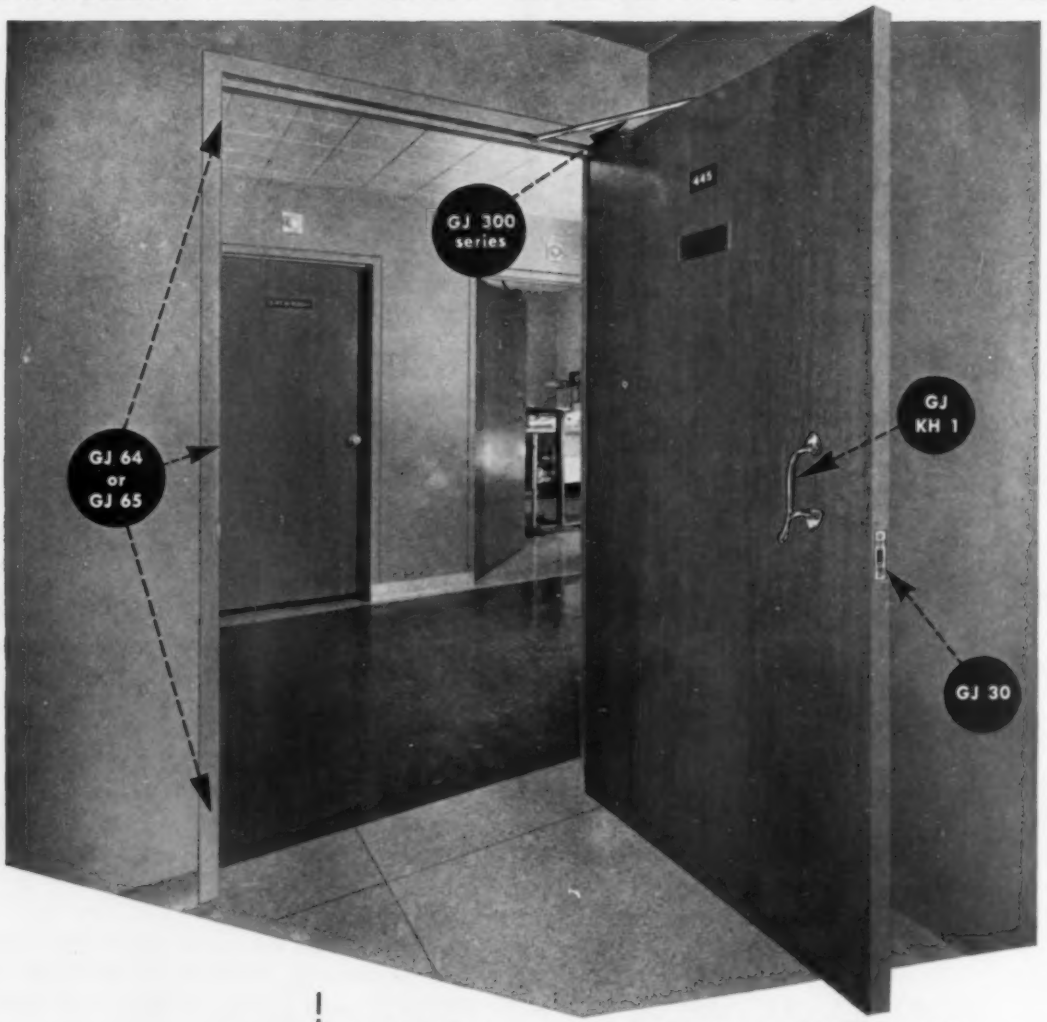
Tomac

American Hospital Supply *corporation*

2020 Ridge Ave., Evanston, Illinois

Division Offices: Atlanta • Chicago • Columbus • Dallas • Kansas City
Los Angeles • Minneapolis • New York • San Francisco • Washington

an ideal specification for silent, efficient
PATIENT ROOM DOOR CONTROL



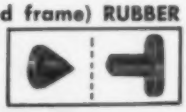
"shall have GLYNN·JOHNSON . . .

GJ 300 series CONCEALED (or surface mounted) OVERHEAD FRICTION TYPE DOOR HOLDER." (Nurse may set door at any desired degree of opening for ventilation or privacy. Door cannot slam open or shut.)

"GJ KH 1 COMBINATION HAND AND ARM PULLS to be mounted back to back as a pair." (Convenient for opening door from either side with sterile hands or when carrying loaded trays.)

"GJ 30 ROLLER LATCH." (Eliminates disturbing latch "clicking" sound. Replaceable rubber roller *silently* engages dirt-free strike. Latching pressure adjustable.)

"THREE GJ 64 for metal frame (or GJ 65 for wood frame) RUBBER SILENCERS." (Form pneumatic air pockets to absorb shock or noise of closing and create constant latch tension . . . no door rattling.)



This ideal specification for patient room doors is used in such outstanding hospitals as:

Kaiser Foundation Hospital, Los Angeles, Calif. Wolff & Phillips, Portland, Oregon — architects

Oak Park Hospital, Oak Park, Illinois Shaw, Metz and Dolio, Chicago — architects

Providence Hospital, Washington, D.C. Faulkner, Kingsbury & Stenhouse, Washington, D.C. — architects

Rhode Island Hospital, Providence, R. I. Shepley Bulfinch Richardson & Abbott, Boston, Mass. — architects

All above hardware can be quickly installed on existing patient room doors.

write for HOSPITAL DOOR CONTROL brochure E-4

GLYNN·JOHNSON CORPORATION

4422 n. ravenswood ave. chicago 40, illinois

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 224. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Portable Serving Unit for Hot Food Assembly

Dietary trays can be made up in minimum time with the new Idealmobile Hot Food Assembly Unit. A continuous belt conveyor carries trays at any of three

speeds, either right or left. Infra-red warmers keep food hot in the top deck which is designed to accommodate four full sized steam table pans or any equivalent combination of fractional pans. The lower compartments are heated with thermostatically controlled heating elements with ten settings available.

Constructed of stainless steel, the new unit is carefully engineered for long service and rugged use. Pilot lights indicate when the unit is heating and the electrical system is junctioned at the control panel. Sturdy push bars at both ends and large, rubber-tired wheels make it readily mobile. The Model FS 100 is designed to speed up the assembly of hot food portions onto plates for increased efficiency of centralized food service. It is eight feet long, 29 inches wide and 56 inches high overall with a top deck height of 35 inches. **The Swartzbaugh Mfg. Co., Murfreesboro, Tenn.**

For more details circle #851 on mailing card.

Custom Minaboard Is High Density Acoustic

Negligible air filtration is permitted in the high density acoustical ceiling material known as Armstrong Custom Minaboard. Dirt and dust do not collect on the interior surface since virtually no air passes through the new board. The perforated material has good sound absorption properties and, because of its high density, also offers excellent resistance to sound transmission. Custom Minaboard is a combination of mineral fiber with special binders to produce a rigid panel with exceptional strength. It is completely fire-safe, can be cleaned with a vacuum cleaner or damp cloth, and may be repainted without appreciable loss of acoustical efficiency. **Armstrong Cork Co., Lancaster, Pa.**

For more details circle #852 on mailing card.

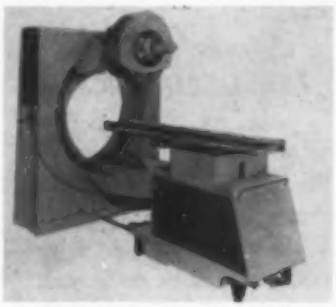
Four-Wheel Base Mobilizes Standby Baumanometer

Wider use of equipment by improved mobility is possible with the new four-wheel base introduced for the Standby Model Baumanometer. The sturdy base has increased weight for stability in use and in motion. The iron casting has Silvertone finish and four conductive rubber casters make it readily mobile. It is easily attached and permits use of the unit in emergency room, wards, out-patient department and wherever the Baumanometer is required. **W. A. Baum Co., Inc., Copiage, Long Island, N.Y.**

For more details circle #853 on mailing card.

Cobalt 60 Therapy Unit Has Patient Safeguards

Patient contact protection is built into the new Westinghouse Cobalt 60 Therapy Unit. Developed to provide appreciable doses to deep lying lesions without exceeding the tolerance of the skin and overlying tissues, the device operates without any contact pressure. Rotation is stopped im-



mediately if the source head should touch either the patient or the table and if the protection should become defective, the machine will not operate. A safety device moves the Cobalt 60 capsule along the axis of the treatment head to the "on" position when treatment begins, and returns it automatically when turned off.

The source head can be rotated completely around the patient, the beam being continuously aimed at the axis of rotation. The operator easily selects any one of the seven cones located in the source head. Only the arc of travel of the head and the time of patient exposure are specified by the operator. The speed of rotation of the source head is automatically regulated by a speed calculator. The table may be pivoted 180 degrees in the axis of rotation and total elevation of the table is 45 cm with 30 cm of cross travel on the top and 100 cm of travel along the longitudinal axis. **Westinghouse Electric Corp., X-Ray Dept., P.O. Box 416, Baltimore 3, Md.**

For more details circle #854 on mailing card.

(Continued on page 190)

Improved Nibroc Towels in Two Colors

White and natural Nibroc Towels are now offered in the improved quality. The new improved towels have greater absorbency so that one towel will dry the hands. Their wet-strength has been increased, yet they are softer than ever and free from lint. Nibroc improved white towels are made with a new bleaching process for extra whiteness and offered in the #2220 Double Multifold. Nibroc improved towels in natural tone are available as #5010, #5020 and #5021. **Brown Company, Berlin, N.H.**

For more details circle #855 on mailing card.

Patient-Controlled Bed Saves Nursing Time

That extra minute or two with each patient to raise or lower the head or the knees or adjust the backrest can now be saved for nurses while patients can have increased comfort with the Selectric Push Button Mattress by Doyle. When patients tire of the same position some worry nurses for constant change and others endure discomfort. With the Selectric Push Button Mattress the patient adjusts the bed just as he wants it with slight finger-tip pressure. If he is not permitted to have any or all adjustments, they can be locked out.

The Selectric permits the automatic control and adjustment of hospital beds by a 4-button switch. It can be operated from any position, from left or right, and the control unit is of a size to fit comfortably in the patient's hand for operation. The hydraulically operated, electrically-controlled power unit connected to the 4-button hand switch is constructed for years of trouble-free service and operates on direct or alternating current. It is sealed for complete safety and all electrical connections are encased in a flame-resistant case. The unit operates to provide smooth start and stop in any position. The illustration shows

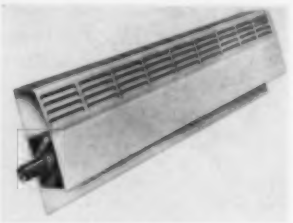
the Selectric in use on a Simmons bed. **Doyle Hospital Products, 2760 W. Warren, Detroit 8, Mich.**

For more details circle #856 on mailing card.

WHAT'S NEW

BFOT Baseboard Components Assembled by Snapping Together

Designed for educational and other institutional installations using hot water or



steam, the new BFOT baseboard can be assembled by snapping the components together. No nuts or bolts are required. The extremely slim unit has a heavy gauge cover, angular louver grille and a long, low appearance. It can be painted to harmonize with any color scheme, and features low first cost as well as low installation cost. Heating elements in steel tube and steel fin, and copper tube and aluminum fin design are available for medium and high output applications. Dampers are lever operated or knob operated as desired. **Dunham-Bush, Inc., West Hartford, Conn.**

For more details circle #857 on mailing card.

Foley Bag Catheter Has Several Improvements

The new Foley Bag Catheter has a number of improvements. The bag lies flat on the catheter shaft and is no larger than the label designated size of the catheter. A newly designed Guide-Seal plug simplifies use. The long needle-directing hole of the Guide-Seal directs the needle to the exact center of the distention duct lumen and avoids inadvertent puncture of its wall. Composition of the Guide-Seal rubber permits repeated punctures without leakage. **General Hospital Industries, 203 S. Portage Path, Akron, Ohio.**

For more details circle #858 on mailing card.

Toilet Compartment Bracket Has Permanent Finish

Polished and anodized extruded aluminum is used for forming the new stirrup bracket for Sanymetal shower and toilet compartments. Used for fastening toilet compartments and shower stall partitions to the backing wall, the new material eliminates the need for maintenance of the metal bracket. The solid non-rusting aircraft-type alloy metal is tough and strong

and will maintain its attractive polished finish for the life of the compartments. **Sanymetal Products Co., Inc., 1705 Urbana Rd., Cleveland 12, Ohio.**

For more details circle #859 on mailing card.

(Continued on page 192)

NEW SIMONIZ

SUPER ANTI-SLIP SAFETY FLOOR WAX WITH LADIUM

WHERE FOOTING MUST BE FOOLPROOF!

This is the new, specially formulated Simoniz safety wax you've heard so much about—the wax you want for the anti-slip protection you demand.

Ladium formulation is the key to the superior performance of Simoniz Super Anti-Slip—a job-tested Simoniz product development that holds all feet in place on all types of floors. This tough, hard, crystal-clear coating gives *lasting* anti-slip performance. No other safety wax provides such amazing all-around performance . . . positive traction, dependable safety under all conditions, and long wear. Self-polishing, yet buffs beautifully if desired. Strips easily. Write today for full details on new Simoniz Super Anti-Slip Safety Floor Wax.

Available in 1-, 5-, 30- and 55-gallon sizes

SIMONIZ®

FOR LONG WEAR—LESS CARE

Simoniz Company (Commercial Products Division—MH-3
2100 Indiana Avenue, Chicago 16, Illinois

☐ Without obligation, please send details on new Simoniz Super Anti-Slip Safety Floor Wax with *Ladium*.

☐ Please send name of nearest Simoniz Distributor.

Name_____ Title_____

Firm Name_____

Street Address_____

City_____ State_____

WHAT'S NEW

Room Air Conditioner Is Readily Portable

A built-in handle facilitates carrying the new Carrier room air conditioner from storage to patient rooms or other areas where air conditioning may be desirable. Weighing 60 pounds, the new unit is easily set up in the window. In addition to cooling, the new conditioner can be reversed in the window to warm a room when central heating is not immediately

available. In damp weather, it can serve as a dehumidifier.

The new portable unit operates on standard power outlets and draws 7½ amperes. Sturdy aluminum grooves on each side accommodate slide-in extenders to make it fit any window. The marproof cabinet has vinyl plastic-covered aluminum finish and is designed to withstand scuffing and abrasions resulting from handling. The unit is operated by one "on-off" switch. **Carrier Corporation, Syracuse 1, N.Y.**

For more details circle #860 on mailing card.

"Sani-Vat" Dye Kit Permits Laundry Dyeing

Four easy steps, utilizing ordinary institutional laundry equipment, can be used to vat-dye hospital garments and linens with the new "Sani-Vat" Dye Kit. A "do-it-yourself" method for giving different or

similar colors to various types of hospital linens and garments, to color-code linens, or to freshen faded materials, is provided in the kit.

A unique new process for applying vat dyes to fabrics quickly, easily and with uniform results forms the basis of the system. The kit contains four packages of materials individually packaged in polyethylene film bags, with complete instructions for the easy, four-step dyeing process. The new "Sani-Vat" Dye Kits, offered in two sizes for fixed loads of fabrics to be dyed, are available in various shades of yellow, gray, tan, beige, pink, violet, mauve, blue, green, navy and brown. **American Aniline Products, Chemical Div., Koppers Co., Inc., 901 Koppers Bldg., Pittsburgh 19, Pa.**

For more details circle #861 on mailing card.

(Continued on page 195)

Food Tray Dispenser Has Noise-Reducing Covering

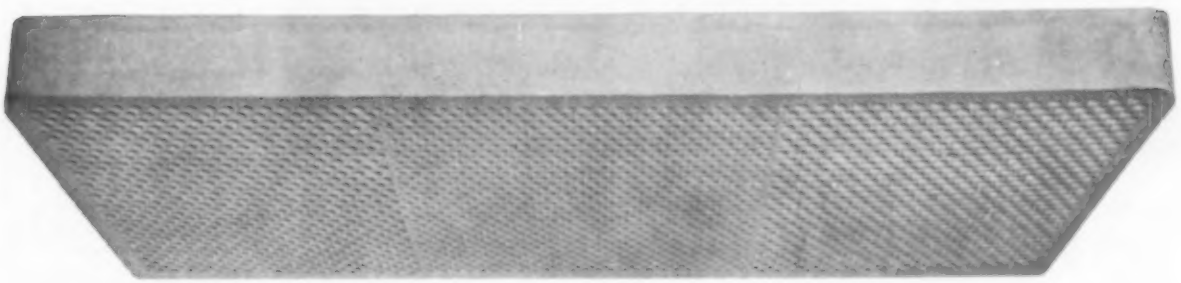
Vinyl neoprene coverings on the tray rests help reduce noise with the new Dispensator Model F16 for tray service. Redesigned with a streamlined appearance,

the new tray cart carries trays on edge so that water will drain off before use. The easy-cleaning framework is also streamlined to accommodate the ball-bearing rotary bumpers which protect walls and doors from damage when the dispenser is moved to and from the cafeteria line or other place of use. Stainless steel is used for the easily removed and cleaned drip pan. **W. H. Frick, Inc., 705 Citizens Bldg., Cleveland 14, Ohio.**

For more details circle #862 on mailing card.

B.F.Goodrich

Only mattress with
certified compression and diagonal coring



Two important things – compression and coring – make the B. F. Goodrich Texfoam latex foam mattress exactly the one your hospital should have.

Only B. F. Goodrich guarantees compression

The patented Texfoam Process makes latex foam differently than any other. Compression can be so completely controlled that B. F. Goodrich can guarantee *every* mattress will conform to exacting hospital standards.

B. F. Goodrich diagonal coring for easier handling

No splitting or creasing here – a B. F. Goodrich Texfoam mattress can be folded, rolled and moved without worry. And it's so light and easy to carry; never needs turning.

Only B. F. Goodrich has real edge stability

A mattress edge is where support without stiffness is needed. B. F. Goodrich Texfoam mattresses put plenty of latex here but eliminate stiffness with two rows of ¼" cores. These are possible only with the patented Texfoam process.

There's a lot more that could be, *and needs to be*, said about the new B. F. Goodrich Texfoam mattress. It's the only mattress with all the advantages of latex foam and a lot more. So why don't you ask your present source all about it. Or write The B. F. Goodrich Company, 419 Derby Place, Shelton, Connecticut.

B.F.Goodrich
Texfoam mattresses

pagemaster®...equally effective "at the summit" and in your operation

Leaders at the December 1957 NATO summit conference in Paris maintained *instant contact* with their staffs by using PAGEMASTER *selective radio paging system* by Stromberg-Carlson.

The efficiency of this system will be just as welcome in your daily routine as it was in the councils of international diplomacy. In your plant—as in the Palais de Chaillot—here is how the system works.

Your key people are equipped with transistorized pocket-size PAGEMASTER receivers. When you need to contact any one of them who may be away from his usual location, your switchboard operator sets two dials on the compact encoder unit (installed next to the switchboard) and flips a switch.

Instantly that person's receiver—and no other—responds with a pleasant buzzing tone, telling him he is being paged. He then goes to the nearest telephone and reports. Each page automatically repeats every 20 seconds until the call is answered.

You can have a PAGEMASTER system installed to meet your particular requirements on purchase or lease plan. As your needs grow, receivers can be added without additional installation cost.

For complete information contact the PAGEMASTER *distributor in your area. Or write to us at 202 Carlson Road.*

STROMBERG-CARLSON
A DIVISION OF GENERAL DYNAMICS CORPORATION
Pagemaster Sales • Rochester 3, N. Y.
Electronic and communication products for home, industry and defense

AUTHORIZED DISTRIBUTORS

Atlanta 3, Georgia
The Lanier Co., 151-55 NW Spring
Baltimore 18, Maryland
John A. Morefield, 3120 St. Paul
Birmingham, Alabama
The Lanier Co., 2129 7th Ave. S.
Boston 15, Massachusetts
DeMambro's, 1095 Commonwealth
Buffalo 10, New York
Regal Electronics, 796 Clinton
Camp Hill, Pennsylvania
John A. Morefield Company
Canton 9, Ohio
George F. Ebel, 3017 NW Cleveland
Sanford, North Carolina
Cmmwlth Assoc., Box 1025
Chattanooga, Tennessee
The Lanier Co., 19 Patten Pkwy.
Chicago 39, Illinois
Boom Electric, 5226 W. Grand
Cincinnati, Ohio
Shaffer Music Co., 1200 Walnut St.
Cleveland, Ohio
J. J. Skinner Co., 25010 Lakeland
Columbus 8, Ohio
Shaffer Music Co., 849 N. High St.
Dallas 31, Texas
Carter Engineering, 6762 Greenville
Dayton 2, Ohio
Copp Radio Labs, 333 W. Monument
Denver 3, Colorado
Empire Radio & TV, 1100 Bwy.
Detroit 7, Michigan
C. A. Nutting, 6353 E. Jefferson
Houston 6, Texas
Audio Center, 1633 Westheimer
Indianapolis, Indiana
Shaffer Music Co., 1327 N. Capitol
Jackson, Mississippi
The Lanier Co., 130 S. President
Jacksonville, Florida
The Lanier Co., 123 W. Beaver
Kansas City 2, Missouri
Engineered Sound & Comm. Co.
18 W. 63rd St.
Knoxville, Tennessee
The Lanier Co., 1800 Grand Ave.
Los Angeles 17, California
Guardian Pacific Co., 6th & Grand
Lubbock, Texas
Radio Paging Service
503 G. Plains Life Bldg.
Memphis, Tennessee
Bluff City Dist. Co., 234 East St.
Miami, Florida
The Lanier Co., 300 NW 12th Ave.
Milwaukee 4, Wisconsin
United Organ Co., 640 W. Va. St.
Minneapolis 3, Minnesota
Stark Radio Supply, 71 S. 12th St.
Nashville, Tennessee
The Lanier Co., 212 6th Ave. S.
Nassau, New York
Hudson Associates
New Orleans 20, Louisiana
E. Emile Rackle, 3855 Airline Hwy.
New York 11, New York
Gross Distributors, 216 W. 14th St.
Oklahoma City, Oklahoma
2-Way Radio, 921 NW 4th
Philadelphia 21, Pennsylvania
J. H. Sparks, Inc., 1618 N. Broad
Pittsburgh, Pennsylvania
Hahn Radio, 700 Penn Ave.
Turtle Creek, Penna.
Portland 11, Oregon
Manchester-Chandler Co.
2915 N. E. Alberta
Richmond 6, California
Watson Communication Systems
10533 San Pablo Ave.
Richmond 19, Virginia
Cottrell Electronics Corp.
408 East Main Street
Rochester, New York
Rochester Radio Supply, 600 E. Main
Salt Lake City 2, Utah
Standard Supply, 225 E. 6th S.
P. O. Box 1047
Spokane 1, Washington
NW Electronics, N. 102 Monroe St.
Springfield 9, Massachusetts
Valley Sound Corp., 958 State Street
St. Louis 13, Missouri
Tesco Telephone Electronic Sound
2612 N. Kings Highway
Syracuse 3, New York
W. G. Brown Sound Equip.
521-527 E. Washington St.
Tampa, Florida
The Lanier Co., 4025 Henderson
Toledo, Ohio
Warren Radio Company, 1002 Adams St.
Turtle Creek, Pennsylvania
Hahn Radio, 700 Penn Ave.
Waco, Texas
Waco Communications, 1213 Clay
Washington 5, D. C.
Tempo Electronics, 1341 L St., NW
EXPORT: Ad. Auriema, Inc.
85 Broad, New York 4
CANADA:
Hackbusch Electronics
23 Primrose Ave., Toronto, Ont.

WHAT'S NEW

Glassine Containers for Sterile Supplies

A simple, inexpensive, transparent and color coded glassine container for sterile hypodermic needles and syringes is available in the new Stanvelopes. Made from a special type of heat sealing glassine, Stanvelopes permit the passage of steam under pressure during sterilization, but are impervious to air and fluids. The glassine seals completely in the heat sealing device. Texture and appearance change slightly after autoclaving.

Hypodermic needle Stanvelopes are two by five inches in size, coded in color. Multiple listing of needle lengths is printed on the outside for marking for quick identification. A three-inch ruler is printed on the back for rapid determination of needle length. Syringe envelopes are made in two sizes from the same glassine and have similar features. **Stanley Supply Co., Inc., 121 E. 24th St., New York 10.**

For more details circle #863 on mailing card.

Wide Stile Door Features Strength and Economy

The Kawneer Wide Stile Door for institutional buildings has been redesigned for greater strength and increased economy due to the extruded tube construction and improved welding technic employed. The deep weld gives a greater penetration of the metal to make the joints as sturdy as the extruded tubes. Butt joints are used for greater strength in corner construction. The bottom rail is a seven-inch extruded section for more attractive appearance and added strength. The improved Kawneer concealed panic device has a simplified mechanism with minimum working parts and reduced maintenance requirements.

Nylon bearings assure quiet operation. Four different types of push-pull hardware are available on the redesigned doors. **Kawneer Company, Niles, Mich.**

For more details circle #864 on mailing card.

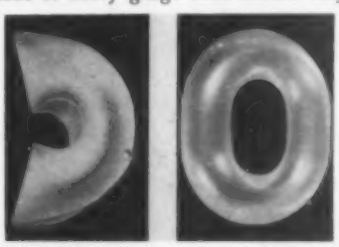
All-Purpose Detergent Is Safe on Hands

Excellent cleaning properties, without harm to hands, are claimed for the new Kelite A-P-C all-purpose, concentrated powdered detergent. Described as 100 per cent active, with no fillers of any kind, the new detergent has high sudsing and suds-staying power and is safe for use on all ordinary surfaces, including aluminum and durable painted surfaces. Kelite A-P-C is soluble in hot, cold, hard, soft or saline water and is designed for cleaning floors and equipment. **Kelite Corporation, 81 Industrial Rd., Berkeley Heights, N.J.**

For more details circle #865 on mailing card.

Comfortaire Inflatable Cushion Serves Dual Purpose

The Nethcraft Comfortaire inflatable cushion serves as an invalid ring cushion or as a neck, arm, knee or leg cushion. Made of heavy gauge clear frosted vinyl,



the pillow is electronically welded and can be quickly blown up with very little effort. The circular construction yields to shifts of body weight, permitting complete patient relaxation when in use on bed or chair. When partially inflated and folded in two, the cushion provides a comfortable support for the neck, arm, knee or leg. The Comfortaire comes with a five by six-inch plastic carrying case, into which it folds for storage or carrying. **The Art Neth Co., 400 Deming Place, Chicago 14.**

For more details circle #866 on mailing card.

(Continued on page 196)

WHAT'S NEW

PowerPak 582 Prevents Surgical Blackout

Power failure, which might plunge the surgery into darkness at a crucial moment, can be overcome with the new PowerPak 582. Interlocked with the major operating light or a general lighting fixture, the PowerPak 582 takes over immediately in case of power failure, but only if the standard circuit was in operation prior to the failure. The new unit is equipped with a dual voltage supply which permits carrying a mixed volt load in any combination that does not exceed a total load of 250 watts. This feature permits illumination from both

major operating lights and general room lights uninterruptedly for over four hours in the event of emergency.

The unit is furnished with three 6-volt batteries connected in series for a total of 18 volts. A tap is taken off the terminal of the second battery for the 12-volt load. All circuits are protected by fuses mounted inside the unit case, and automatic protection is provided to prevent battery overcharge. **The Wilmot Castle Co., 1904 E. Henrietta Rd., Rochester, N.Y.**

For more details circle #867 on mailing card.

Negastat Solution Eliminates Static Build-Up

Specific formulas of Negastat, the anti-static solution, are now available for operating room use. Designed to eliminate static build-up, Negastat solution is effective for use on plastic valves and connectors, rubber sheeting and tubing, rebreathing bags, cart wheels and casters. Formula 172 is designed to make the operating room floor static-free. Negastat formula 103 for laundering personnel clothing and hospital linen is equally effective.

Negastat is non-toxic and will not injure or stain skin, fabrics or other surfaces. It deodorizes and sterilizes while removing static. Negastat in Formula No. 105X is supplied in a 12-ounce aerosol container for push-button spray application to neutralize static build-up on operating room equipment. Formula No. 103G for the hospital laundry is supplied in 12-ounce bottles, and Formula No. 172 for hospital floors, in one gallon containers. **Functional Products, Warsaw, Ind.**

For more details circle #868 on mailing card.

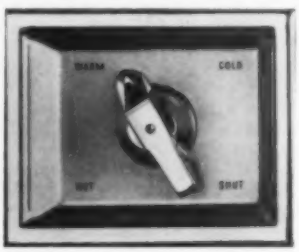
Electric 3-Piece Battery Delivers Large Batches of Coffee

Quick delivery of large quantities of coffee is possible with the new Amcoin electric three-piece battery. The all-glass interior coffee urns are available in two models: two 4-gallon side urns and one 15-gallon hot water boiler, or two 8-gallon side urns and one 20-gallon hot water boiler. A superior brew of coffee is delivered and the human element from one batch to another is eliminated. There is no re-pouring and temperature is maintained automatically at the proper level. **Amcoin Corp., Div. of The Holly Corp., 122 E. 42nd St., New York 17.**

For more details circle #869 on mailing card.

Thermostatic Shower Valve Is Fully Recessed

"The Recesso" is the name given to the new Lawler Thermostatic Control



Valve. The completely recessed thermostatic shower mixing valve has no protruding edges. Elimination of any danger of injury through cutting or tearing the body in case of falls, and easier maintenance are features claimed for the new valve. The recessed design also blends into modern design. "The Recesso" also has a new, improved thermostatic valve for more comfort and safety in showering. **Lawler Automatic Controls, Inc., 453 MacQuesten Pkwy., Mount Vernon, N.Y.**

For more details circle #870 on mailing card.

(Continued on page 198)

Floor Maintenance Materials and Equipment

MULTI®-CLEAN Method

SCRUBBING MACHINE—For floors, rugs and carpets. Heavy gauge steel tank, easily filled, non-spilling. Fingertip solution flow and dual-purpose safety switch. Balanced construction, adjustable handle. 8 ball bearing gear unit. Capacitor motor with sealed bearings, no brushes. 3-conductor cord. Sizes: 12", 14", 16", 19" and 22". Attachments for every floor maintenance job.

FLOOR MACHINE—For every type floor work . . . scrubbing, waxing, polishing, troweling, grinding, dry cleaning. Same balanced construction and features as Scrubbing Machine. Quickly converted to scrubbing machine by attaching solution tank and control lever. Five models: 12", 14", 16", 19" and 22".

MC-31—31" machine with covering area of 855 sq. in. for cleaning, polishing, steel wooling hallways and large unobstructed floor areas. Heavy-duty construction, operation similar to other models.

EXPLOSION-PROOF FLOOR MACHINE—For mechanical floor maintenance in hazardous areas without danger of fire or explosion. Can be used near and in combustible material with absolute safety. All electrical components are listed by U/L. Brush sizes: 14" and 16". Heavy-duty switch and 40 ft. Neoprene-covered 3-conductor cord.

LITE-12 FLOOR MACHINE—Scrubs, waxes, polishes, steel wools all types of floors. Low, balanced construction, efficient, rugged. Finger-tip lever-operated momentary contact type switch. Direct ball bearing greaseless gear drive. ½ hp AC motor, 30' cord. Brush diameter 12". Weighs only 38 lbs. with brush. Easy on-off attachments. U/L listed.

INDUSTRIAL VACUUM CLEANERS—MCV-214 and MCV-220, 10 and 16-gal. capacities. Wet or dry pickup. Heavy-duty, portable, quiet, safe, versatile. 1 hp Universal motor, independent cooling system, electronic shutoff prevents flooding. 3-stage turbine, water lift minimum 64". 30' 3-conductor cable, 2 hp switch, 10' 1½" easy-flex white hose, molded rubber ends. Standard attachments available for all wet and dry vacuuming jobs. Also available in extra quiet hospital models.

D-100 VACUUM CLEANER—Wet or dry pickup, powerful, portable. Weighs only 29 lbs. Minimum 66" water lift. Long-life precision ball bearings. ¼ hp Universal motor. Suction created by 2-stage turbine. Overflow safety fuse. Tank capacity 3½ gals. wet or ½ bushel dry material. Full line of attachments. **D-110**—Similar, except recommended for dry use only.

E-200 VACUUM CLEANER—Medium priced all-purpose industrial vacuum cleaner. ½ hp AC-DC 115V motor with long-life precision ball bearings. Suction created by 2-stage turbine. 45" minimum water lift. 20-gauge steel tank holds 10 gals. liquid, 1½ bu. dry material. Wt., 48 lbs. Highly portable. Attachments for all cleaning jobs. U/L listed for wet and dry pickup.

F-300 VAC-BLOWER—All-purpose industrial vacuum cleaner and a powerful blower. 16 lb. detachable power head and dust bag for portable blowing or vacuuming. 10-gal. steel tank, 1 hp. AC-DC motor. 43" minimum water lift. Complete unit weighs only 50 lbs. Easily portable. Wet or dry pickup. Attachments for every cleaning job.

G-400 VACUUM CLEANER—Similar to E-200 except has 1 hp motor and 63" water lift. Wt., 53 lbs. U/L listed.

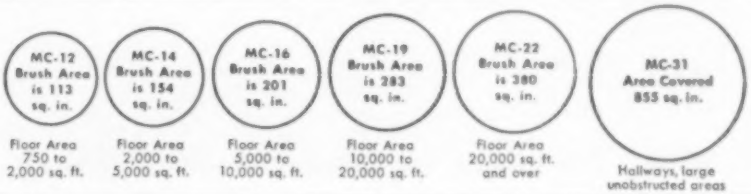
H-500 EXPLOSION-PROOF VAC—U/L listed for safe wet or dry vacuum cleaning where explosive gases, liquids, or dust are present. ¾ hp enclosed motor. Permanently sealed ball bearinged power unit. 62" water lift. Aluminum tank holds 10 gallons or 1¼ bushels. Static-free bronze wool filter. Explosion-proof switch; 40', 14 gauge 3-conductor cord. All parts and accessories of spark-resistant brass or aluminum. Listed by U/L for Class 1, Group D and Class 2, Group G hazardous locations.

ADD-A-TANK—Adapts any industrial vacuum cleaner for heavy volume pickup. Fits 30-gal. or smaller ash can or drum. For cleaning boiler flues, fire boxes, chimneys, milling machinery, grain elevator pits.

KON-VERT-O-VAC—An assembly to convert 30 to 55 gal. drums for use with MCV series or G-400 heads. Especially handy for cleaning out sumps, picking up shavings of other bulky material. Wet or dry pickup.

SELECTING MACHINE TO FIT FLOOR AREA

For economy and efficiency, here is a guide to selecting the proper size floor machine with respect to area.



MULTI-CLEAN TESTED AND PROVED FLOOR FINISHES

BLUE BLAZES CLEANER—Concentrated non-ionic synthetic cleaner for all floors. PH of 7 in concentrate cleans completely in hard or soft, hot or cold water. Easy rinsing—means no soap scum, no soap film. Contains HCP. Approved by Rubber Mfrs. Ass'n. Meets or exceeds Asphalt Tile Institute specs.

SUPER SAFETY CLEANER — With HCP (high cleaning power). Lifts stubborn dirt and grime off floors quickly, holds it in suspension for easy removal. Coconut oil base. Safe for all floors. Cleans perfectly in hardest water. Contains minimum soap solids of 26%. Goes twice as far as ordinary cleaners. Can be mixed to remove wax. Approved by York Research Corp. and Rubber Mfrs. Assn. Meets or exceeds Asphalt Tile Inst. specs.

WAX REMOVER—Safe for all floors. Cleans floor and removes wax buildups. Odorless, non-toxic, non-inflammable. Easy, quick, inexpensive to use. Contains powerful emulsifying agent that works in 10 to 15 minutes. Meets or exceeds Asphalt Tile Institute specs.

REMOVOIL—A Solvent Cleaner and Degreaser. Makes oil-soaked floors look like new. Non-explosive, non-toxic. Removes rubber burns from gym floors. Degreases all kinds of metal and alloys. Protects against rust and corrosion. Easy to use, highly concentrated.

WATERPROOF WAX—Provides lasting beauty, longer wear for all types of floors. Excellent anti-slip qualities. Carnauba base, self-polishing, water emulsion wax. Resists scuffing, won't crack, chip, flake, waterspot or discolor. Listed by U/L. Approved by York Research Corp. and Rubber Mfrs. Ass'n. Meets or exceeds Asphalt

Tile Institute specs. Available with special anti-slip formula.

LIQUID SPIRIT WAX—For sealed surfaces. Cleans and waxes in one operation. Consists of vegetable and mineral waxes reinforced with special resins. Produces hard, flexible, easily cleaned surface. For all floors except asphalt and rubber. Maroon, tile red, brown, green, gray and colorless.

PENETRATING SEALER—Polymerized for greater penetration and thorough sub-surface sealing of all wood floors. Protects against wear, moisture, dirt. Stands up in heavy traffic. Listed by U/L. Approved by Maple Flooring Mfrs. Ass'n.

GYM FINISH—Provides hard, durable, easily cleaned high gloss surface, impervious to rubber burns. Assures fast, non-slippery footing. Meets Maple Flooring Mfrs. Ass'n specs. Listed by U/L.

SEAL AND VARNISH STRIPPER—Removes finish from wood, concrete or terrazzo. Easy to apply, no after-wash. Non-inflammable. Lifts old finish in 30 to 40 minutes. Won't raise grain in wood or harm basic floor materials.

CONCRETE HARDENER AND ETCHER—Cleans, etches, hardens, dustproofs. Assures even etching on all concrete surfaces. Gives longer life, extra strength to floors.

NEO-DRY CONCRETE SEALER—(Rubber Base). Beautifully colors concrete floor surfaces. Fast-drying, easy to apply, prevents dusting and chipping. Highly resistant to alkali and other corrosive agents. Colors: tile red, brown, gray, light gray, green, white, black, natural. Listed by U/L as anti-slip.

CONCRETE PRESERVER — (Bakelite Base). Provides tough, sanitary, colorful finish and longer life for new or old concrete. Prevents dusting. High resistance to abrasion, water, grease, oils, alkali and soap. Especially recommended where petroleum spillage occurs. Colors: maroon, tile red, brown, green, gray, light gray, natural. Listed by U/L as anti-slip.

KWIK-COLOR SEAL—For old or new concrete. Prevents dusting. Gives controlled penetration. Contains emulsified plastic resin. Tile red and light gray.

ASPHALT TILE PRESERVER — Penetrates and seals in one application. Preserves color and finish on old, faded floors. Resists grease, water, soaps, alkalies. Dries hard in 30 minutes. Listed anti-slip by U/L.

SUPER FLOR-TREAT—Protects and seals all types of floors. Dries to tough, attractive finish in 1 hour. Ideal for light colored floors. Can be used alone or as base for wax. Odorless water emulsion, non-yellowing plastic resin. Non-inflammable. Approved by Rubber Mfrs. Ass'n and U/L listed. Meets or exceeds Asphalt Tile Inst. specs.

TERRAZZO SEALER—One-coat application brings out natural beauty and vivid terrazzo colors. Long-lasting. Seals the pores, prevents chipping and corrosion. Resists water, acids, alkalies, soaps, grease and solvents. Anti-slip U/L listed.

FLOOR DRESSING—An ideal mop treatment for all types of floors. May be used on all wood, terrazzo and concrete floors, on waxed or treated linoleum, asphalt or rubber tile floors. U/L listed.

MULTI-CLEAN PRODUCTS, INC.

MULTI-CLEAN PRODUCTS, INC., Dept. MH-1-38, St. Paul 16, Minnesota

Please send information on following products:

_____ _____

_____ _____

Name _____

Address _____

City _____ Zone ____ State ____

WHAT'S NEW

Cup Dispensing Tray of High-Impact Plastic

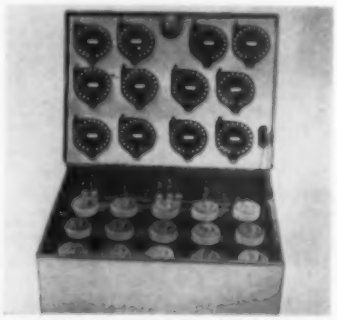
A functional tray molded of high impact styrene plastic is introduced by Lily-Tulip as the VIP Cup Dispensing Tray. Designed for "Very Important People," such as patients, patrons and the like, the tray is designed to hold any standard carafe or pitcher and a generous supply of Lily cups. It is conservatively styled in gray with a built-in cup compartment with lift-off plastic cover to protect the supply of cups. **Lily-Tulip Cup Corp., 122 E. 42nd St., New York 17.**

For more details circle #871 on mailing card.

Narcotic Control Cabinet and Counter-Dispenser

Accuracy in narcotic records without time-consuming counting is offered with the new Cole-Sewell Narcotic Control Cabinet and Counter-Dispenser. A running count of the drugs is kept while tablets are dispensed one at a time. The system is simple to operate. The pharmacist loads the dispensers, marks the inventory sheets and delivers dispensers to nurses' stations on request. Tablets are dispensed by pushing a button.

The storage bottles hold 30 large capsules or tablets. When loaded, the indicator on the counters reads 20 in and 0 out. As narcotics are dispensed, the "in" slot automatically shows the number of tablets in the dispenser. All varieties of narcotics can be accommodated in the dispensers. The cabinet has a metallic gray finish and is equipped with an attachment



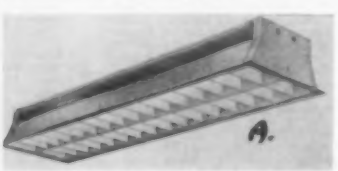
for securing it to a desk, labels for rapid identification and two keys. Exclusive distributor in the hospital field is **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #872 on mailing card.

Louver Fin Lighting Troffer Reflects Light Downward

The parabolic contour of the new Curtis louver fin design lighting troffer is engineered to reflect light downward onto the work surface. At the same time, light is reflected away from the critical viewing angles, reducing glare and brightness. The new louver fin, called LBQ (Low Brightness Quality), is available with the new line of Curtis Eye-Comfort Alzak troffers.

Another important feature of the LBQ design is its extreme rigidity which eliminates the possibility of damage and misalignment during shipping, installation,



cleaning or relamping. The extruded aluminum of the parabolic cross section has a diffuse Alzak finish which is easily cleaned with a dry cloth.

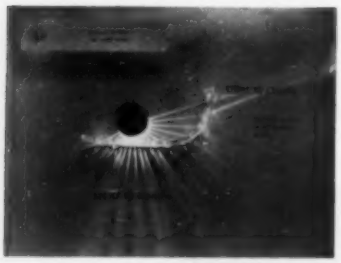
The Low Brightness series also includes a heavy duty flat Alzak louver fin and a unit without louvers. Troffers are also furnished in steel construction with flat fins and white Fluracite finish. The new louver fins are engineered to provide high levels of illumination with maximum visual comfort and excellent control of glare and brightness. **Curtis Lighting, Inc., 6135 W. 65th St., Chicago 38.**

For more details circle #873 on mailing card.

(Continued on page 200)

WHAT'S NEW

Light and Vision Institute Demonstrates Light Control



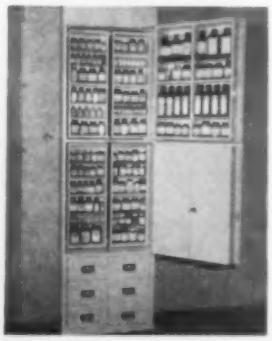
A lighting education center for the solution of lighting problems is available to administrators, architects, engineers and others concerned with hospital planning and construction. The rebuilt Holophane Light and Vision Institute has facilities for the demonstration of all kinds of prismatic light control and the showing of the newest developments in the field.

The modernized Institute employs Prismorama and other technics to demonstrate how raw light can be directed and controlled to make seeing efficient and easy. It tells the story of brightness, shows the facts of color, teaches the value of measurements and plans and illustrates the economic values of lighting by experts. **Holophane Company, Inc., 342 Madison Ave., New York 17.**

For more details circle #874 on mailing card.

Nurses' Station Unit for Condensed Storage

Maximum condensed storage for pharmaceuticals and other material is provided in the new McKesson Nurses' Station Unit. The attractive, efficiently planned unit stands seven feet high, is two feet wide and 18 inches deep. Twelve feet of straight shelving are provided in the three



compartments, each protected by a door. A locked narcotics cabinet is mounted on the inside lower door, and locks are provided on the upper two sections. Six drawers for ampule storage or pull-out shelves for six one-gallon jars make up the bottom section.

Maximum storage space is provided in minimum space in the new Station Unit. The outside doors of the unit are locked to protect the pharmaceuticals from unwarranted access. The narcotic cabinet is master-keyed to be available only through the head nurse. The storage unit is made of kiln-dried lumber, finished in hand-rubbed lacquer enamel in white, blossom pink, meadow green or powder blue. **McKesson & Robbins, Inc., 155 E. 44th St., New York 17.**

For more details circle #875 on mailing card.

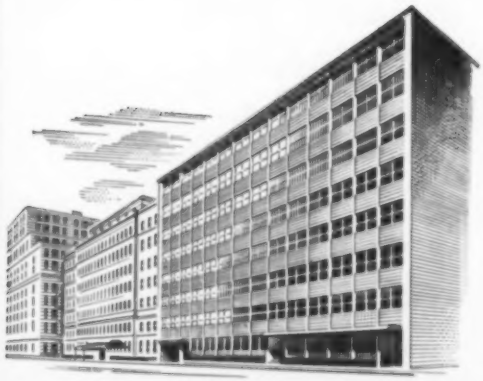
Scale Model Skeleton of Durable Plastic

Durable and washable, "Mr. Bones" is an anatomically accurate scale model of the human skeleton made in realistic, dur-

able, washable plastic. It hangs on a formed metal stand 12 inches high and is designed for use in teaching, explaining treatment to patients and demonstrating procedures. The articulated model is easily assembled and easy to care for since it can be handled without danger of breakage and can be easily cleaned. **V. Mueller & Co., 330 S. Honore St., Chicago 12.**

For more details circle #876 on mailing card.

(Continued on page 202)



How Mt. Sinai Hospital gains nursing time, cuts foot travel, speeds all services!

AUDIO-VISUAL NURSE CALL SYSTEM. At Mt. Sinai, Executone's two-way voice communication between patient and nurse cuts nurse's foot travel more than 60%...allows nurse more time for actual patient care.

New York's famed Mt. Sinai Hospital has pioneered in the application of electronic voice communication. Starting 14 years ago with its first Executone Intercom System in the Radiology Department, Mt. Sinai quickly extended the use of this modern time-saving equipment.

Today, Executone is an integral part of Mt. Sinai, serving the entire hospital. With 325 beds already served by Executone's Audio-Visual Nurse Call System, Mt. Sinai has applied other Executone intercom and sound systems to its many services and departments. Thousands of needless steps are saved daily at Mt. Sinai with Executone—clear, distinct two-way conversations take place at the touch of a button. The over-all result is more personalized patient care and improved administrative efficiency.

Hospitals throughout the nation have discovered the effectiveness, economy and complete dependability of Executone for *all* services. Executone's Audio-Visual Nurse Call System alone is now serving over 12,000 hospital beds. Find out—*without any obligation*—how Executone can work for you as it does for Mt. Sinai and the entire hospital field. Write to Dept. H-8 for further information: Executone, Inc., 415 Lexington Avenue, New York 17, N. Y.

(In Canada—331 Bartlett Avenue, Toronto.)

Executone

HOSPITAL COMMUNICATION SYSTEMS

NON-CORRIDOR PAGING. Doctors' paging calls at Mt. Sinai are reproduced at Nurses' Stations—not in Patient Corridors. (Arrow indicates paging unit.)

CENTRAL KITCHEN COORDINATION. An average of 6600 meals are served daily. Executone speeds activities with communication between Steward, Dietician, Food Preparation and Serving areas.

RADIOLOGY TRAFFIC CONTROL. Handling of patients coordinated through Executone between technicians, Reception area, Dark room, Film Files, and Chief Radiologist.

WHAT'S NEW

Foldoor Folding Partition Is Sound Retardant

Separation of both space and sound is provided in the new Dual Sound-Retardant Foldoor Folding Partition. Two special

sound retardant Multi-V Foldoor units are installed back to back on parallel tracks, operating as a single door with joined lead posts, in installations where sound insulation is desired. Either cornice or recess track head details are supplied, according to need. Each door unit can be erected separately, the lead posts being joined afterward with a covered steel plate for simplified installation.

The narrow Multi-V frame construction keeps stacking space and dimensions at a minimum. When extended the profile of the new door is 11⅝ inches wide and it is 13¾ inches wide when stacked. **Holcomb & Hoke Mfg. Co., Inc., 1545 Van Buren St., Indianapolis 7, Ind.**

For more details circle #877 on mailing card.

Mobile Chest for Ice Storage

Designed for easy, sanitary and economical storage and distribution of ice cubes and chips, the Mobile Ice Chest is mounted on a cart at a convenient work height. The fiberglass insulation preserves the ice and provides minimum cold leakage. The center hinged lid lifts out for easy cleaning and a rubber hose attachment assures complete drainage.

The cart is constructed of tubular steel with steel angle base frame. A flared out

stainless steel push handle 36 inches high and swivel casters make the cart readily maneuverable. Available with either five and ten or four and eight-inch ball bearing demountable rubber tired wheels, the cart has overall dimensions of 19 by 35⅝ by 36 inches. **Nutting Truck & Caster Co., Faribault, Minn.**

For more details circle #878 on mailing card.

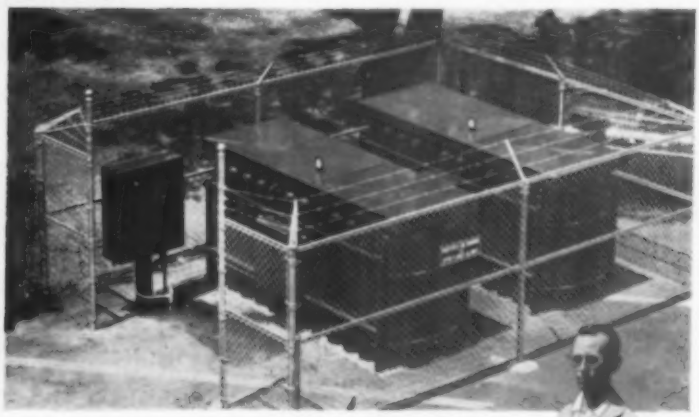
(Continued on page 204)

Whatever your requirements . . . there's a **LINDE** OXYGEN SUPPLY SYSTEM for your needs

A continuous, dependable supply of pure oxygen is essential to your hospital. And for whatever quantities of oxygen you may need, there's a LINDE oxygen supply system *just right* for your requirements.

◀ **IN CYLINDERS:** LINDE oxygen is supplied in standard cylinders, which can be manifolded to assure economical use of the oxygen you buy.

CASCADE oxygen provides a continuous flow of dry, gaseous oxygen for your hospital piping system. Manifold cylinders on your site are filled from special tank trucks of liquid oxygen, converted into gaseous oxygen as cylinders are filled. ▼



▲ **DRIOX** oxygen is shipped and stored in liquid form in specially-designed, insulated containers. Self-contained vaporizing equipment automatically converts liquid oxygen to gaseous oxygen for your piping system.

NEW—LIQUID OXYGEN IN CYLINDERS! One of LINDE's new LC-3 liquid oxygen cylinders contains the equivalent of 12 standard cylinders of gaseous oxygen—occupies only one-third the space. This large capacity cylinder can be handled and moved as needed. ▶

With today's high demands, your present oxygen supply facilities may be outmoded and inadequate. To get more information about LINDE oxygen supply systems, just call your nearby distributor, or write the LINDE office nearest you.

Linde
TRADE-MARK

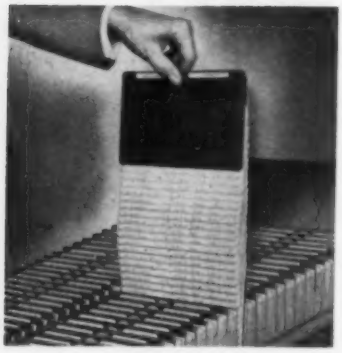
UNION CARBIDE

LINDE COMPANY
Division of Union Carbide Corporation
30 East 42nd Street, New York 17, New York

In Canada: Linde Company
Division of Union Carbide Canada Limited

The terms "Linde," "Cascade," "Driox" and "Union Carbide" are registered trade-marks of Union Carbide Corporation.

WHAT'S NEW



Activisible Record System Saves Time and Space

A new development in Acme Visible Record Files is the Activisible Record Pack. A pack of 25 record cards requires only a half-inch of filing space, yet when opened the cards lie flat in natural posting position for easy handling. When closed, the pack fits into the small space in trays, desk or file drawers, tubs or rotaries, or can be carried in the pocket if required.

Activisible file units are removed with a single lifting motion which opens them to fully visible records. Each card is securely locked in place and cannot become lost or misfiled, yet a single card or a group of cards can be removed or attached in a matter of seconds. Cards are supplied with the hanger attached and roll smoothly through the typewriter for indexing. **Acme Visible Records, Inc., Crozet, Va.**

For more details circle #879 on mailing card.

Televiewer System Is Complete Closed Circuit TV

A complete closed circuit broadcasting and reception system is now available in the Televiewer. The one facility can be used for entertainment and diversional therapy. It consists of a wall-mounted television and radio combination for each patient's room and a pillow speaker for each bed. Finger-touch controls for TV channel and radio station selection are operated by the patient from his bed. The patient also uses the controls to switch from radio to television to closed circuit broadcasting within the hospital. Volume and fine tuning are controlled through the pillow speaker which permits patients to enjoy programs without disturbing others.

The Televiewer system permits hospitals to use tape recorders, record players and "live" broadcasts on radio or television. Informational talks, religious programs, special music for lobbies and work areas, chapel services and other programs are

possible with the system, in addition to local and network shows. **Dahlberg, Inc., Golden Valley, Minneapolis 27, Minn.**

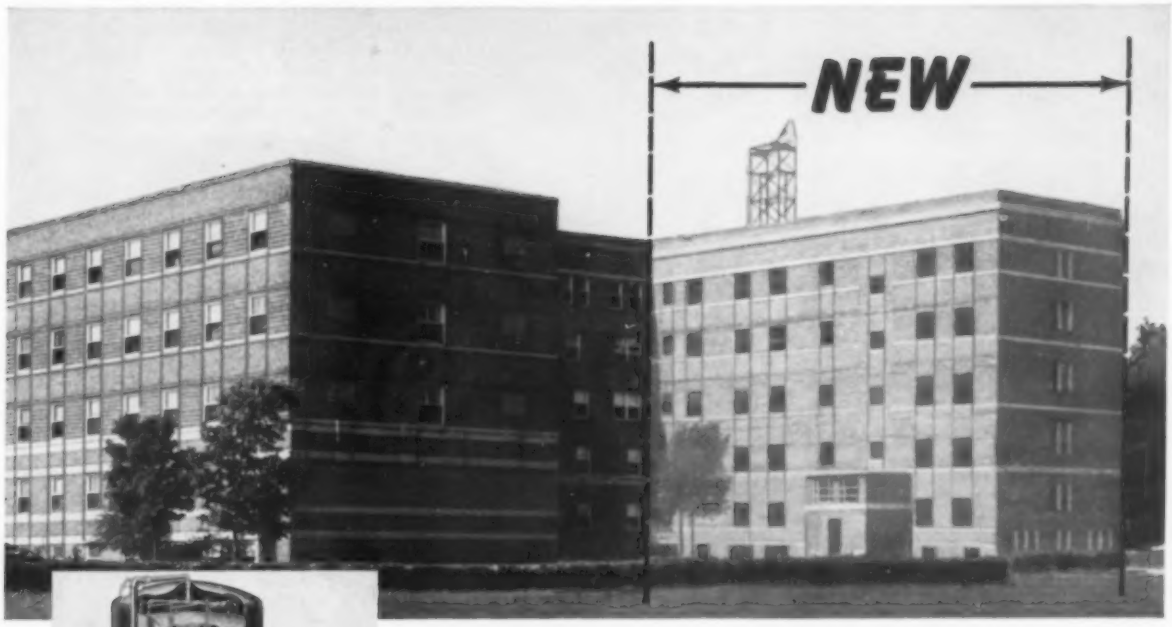
For more details circle #880 on mailing card.

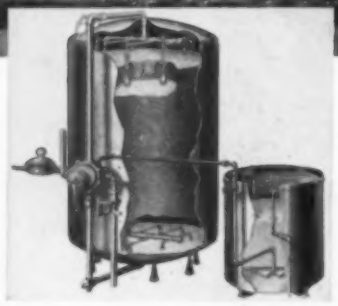
Nebulizer-Humidifier Has Automatic Oxygen Limitation

Forty per cent oxygen limitation for incubator use is a feature of the new Continental Nebulizer-Humidifier. It can be used with all types of oxygen therapy equipment, including infant incubators, croup tents, oxygen masks and tents and tracheotomy equipment. Humidity of 100 per cent saturation can be provided as well as nebulization of medications in fine mist for respiratory disorders. A non-breakable plastic bottle of 500 cc capacity is supplied for prolonged use, as well as 30-inch non-conductive multiflex tubing for a variety of uses, and an all-chrome stand with rubber suction cup base which may also be hung with various types of equipment. **Continental Hospital Industries, Inc., 18624 Detroit Ave., Cleveland 7, Ohio.**

For more details circle #881 on mailing card.

(Continued on page 206)





Are your water conditioning plans in step with your expansion plans?

Up to 44% more Soft Water from the ELGIN "DOUBLE-CHECK" WATER SOFTENER

This remarkable output is from a softener of given size using a given type of zeolite. The Elgin "double-check" design accomplishes this — prevents loss of costly zeolite — saves salt. Both automatic and manual types available.

Dealkalizers prevent corrosion of steam condensate return lines and equipment.

Deionizers are being used by hospitals to produce mineral-free water, equivalent to distilled water for many purposes, and produced at a fraction of the cost of distillation.

Deareating Heaters supply dollar-saving preheated boiler water free of objectionable CO_2 and oxygen.

Elgin services also include modernization of existing softeners when feasible. By adding "Double-Check" manifolds and refilling with new high capacity zeolites, capacities of old softeners—*any make*—have been stepped up from 3 to 10 times. Our representative will be glad to determine what can be accomplished by modernizing your softener.

It will pay you to make adequate, up-to-date water conditioning part and parcel of your expansion plans. If you don't, you may find later that it will cost you a lot more to catch up with your needs.

Commendable though they are, not all of today's great advances have been made in facilities for diagnosis and therapy. Water conditioning techniques have been moving ahead too . . . and there is no better example of new and better ways than you will find in Elgin water conditioning products and services.

Some of the Elgin products that have a place in your plans are high-lighted here . . . the remarkable Elgin "Double-Check" Softener that gives you 44% more soft water from a softener of given size . . . Elgin Dealkalizers to increase life of return piping . . . Elgin Deionizers to replace distillation at a big saving . . . Elgin Deareating Heaters to cut fuel costs and prevent corrosion.

Yes, whether your hospital is large, small, old, new, or expanding, Elgin's longer and broader experience is the modern, practical, efficient, and therefore *economical answer* to your water conditioning problem.

Write for Bulletin 611C, or, better still, let us put you in touch with your local Elgin representative.

ELGIN WATER CONDITIONING SINCE 1908

ELGIN SOFTENER CORPORATION 50th Anniversary 1958 WATER CONDITIONING

ELGIN SOFTENER CORPORATION
144 North Grove Avenue • Elgin, Illinois

Representatives in Principal Cities • In Canada: G. F. Sterne & Sons, Brantford

WHAT'S NEW

Sierra Arm Board Fits All Operating Tables

A lightweight unit which can be quickly attached and re-positioned by means of spring-loaded clamps, the new Sierra Arm Board is designed to fit all operating tables. It is attached to the table under the mat-

tress and has two arm trays to provide for parallel position on one side of the table or extension to both sides. Conductive rubber over fully adjustable foam rubber pads covers both trays.

The upper tray rotates 360 degrees in a horizontal plane and swivels upward and downward from horizontal on a six-inch arm. The lower tray rotates through 340 degrees on its stanchion and can be raised, lowered and locked on its four-inch rod. A spring-loaded mechanism ensures positive locking for both trays. The entire unit is light in weight and can be quickly attached or re-positioned with the special clamps. **Sierra Engineering Co., 123 E. Montecito, Sierra Madre, Calif.**

For more details circle #882 on mailing card.

"Easy Opener" Package for Baking Mixes

The institutional sizes of General Mills baking mixes are now available in a new modern gray and red carton package with the "easy opener." The complete line of mixes is put out in the new package, which includes user service features such as baking hints, variety recipes and a menu planner section for each product. **General Mills, Inc., 400 Second Ave. S., Minneapolis 1, Minn.**

For more details circle #883 on mailing card.

Self-Polishing Floor Dressing Contains No Wax

The new Masury-Young Poly-Glo floor dressing is a long-wearing, self-polishing substance which contains no wax or solvents. It is easy to apply and may be used on asphalt, rubber, linoleum, vinyl, sealed wood, terrazzo, concrete and all other resilient and non-resilient floors. Poly-Glo dries in minutes leaving a hard, glossy transparent film without buffing. It is supplied in five, 30 and 55-gallon containers. **Masury-Young Co., 76 Roland St., Boston 29, Mass.**

For more details circle #884 on mailing card.

Storage Space Reduced With Coil-Wal Partitions

Its own storage box into which the Coil-Wal automatic partition coils, cuts storage space as well as over-all installation costs for movable partitions. The new type partition is low in initial cost and requires no heavy overhead trusses or beams for installation. It incorporates safe, straight-line travel and smooth, quiet electrical-mechanical action that is readily adaptable to use in institutions requiring large, eco-

nomical movable partitions.

Coil-Wal Automatic Partitions of narrow wooden slats of straight vertical grain Douglas Fir are constructed to prevent reverberations, reduce sound and to provide high acoustical qualities. Slats are joined by lightweight pre-stressed steel cables for a close-knit vertical position. The supports are of minimum weight, and the self-contained partitions require no special storage cabinets. Coil-Wal Partitions are custom made to any size and structural requirement and are available in pull-push and pull-crank types for smaller installations and automatic electric actuation for larger openings. **Dubuque Products Inc., Dubuque, Iowa.**

For more details circle #885 on mailing card.

(Continued on page 208)

with Carrier the ice is right...and capacity's certified in writing

Carrier offers you a choice of 15 ice machines, so you get *just* the ice you need. It's the most complete line there is. That's why you'll never hear a Carrier man ask, "But won't this ice do just as well?"

Carrier alone gives you ice production with Certified Capacity in writing. And this production figure is determined by air and water temperatures where you live, not by hypothetical laboratory conditions. That's why you'll never hear a Carrier man say that ice capacity is "up to" so many pounds a day.

Your Carrier dealer has a lot of interesting things to point out—like savings of 80% or more on ice bills. Phone him today. He's listed in the Classified Directory under Ice Making Equipment. Or write to Carrier Corporation, Department 123, Carrier Parkway, Syracuse 1, N. Y.

ICEMAKERS for cubes or crushed | CHIPMASTERS for chips | FLAKEMASTERS for flakes

Carrier AIR CONDITIONING · REFRIGERATION

WHAT'S NEW

Constant Floor Contact Removes Static With Legstat

Legstat is a new device to drain static from the body to the conductive floor. Worn under the arch of the shoe, it ensures constant contact with the floor. It is secured to the shoe by an elasticized band which fits comfortably around the upper part of the shoe. A lightweight metal plate worn in a garter assembly on the outside of the leg makes the necessary skin contact. A snap-on button attaches the unit. The new Legstat unit can be laundered periodically without damage. **Walter G. Legge Co., Inc., 101 Park Ave., New York 17.**

For more details circle #886 on mailing card.

Mobile Humidifier-Aspirator for Inhalation Therapy or Suction

The Hydrojette is a new self-powered humidifier-aspirator designed for bedside or chairside inhalation therapy or suction anywhere in the hospital. Used primarily

as an open-air humidifier, the Hydrojette may also be used inside a canopy when oxygen is required. The cool-vapor delivery head can be easily moved to any position by the patient as well as the nurse.

The new unit occupies only two and two-tenths square feet of floor space with its flexible, counterpoised arm folded down on the vertical columns. With the arm extended, the machine protrudes less than a foot from the side of bed or chair. Ruggedly built, the Hydrojette is easily and quietly rolled to ward or room where needed to prevent dehydration or for extra humidity. It is powered by a trouble-free diaphragm-type pump. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #887 on mailing card.

Portable Vegetable Peeler Handles Large Load

A 15-pound load of vegetables can be peeled in approximately one minute with the new Univex Model "H" portable peeler. It may be used on the drainboard of any sink and requires no installation or plumbing. Peelings are pulverized to flow down the drain without danger of clogging.

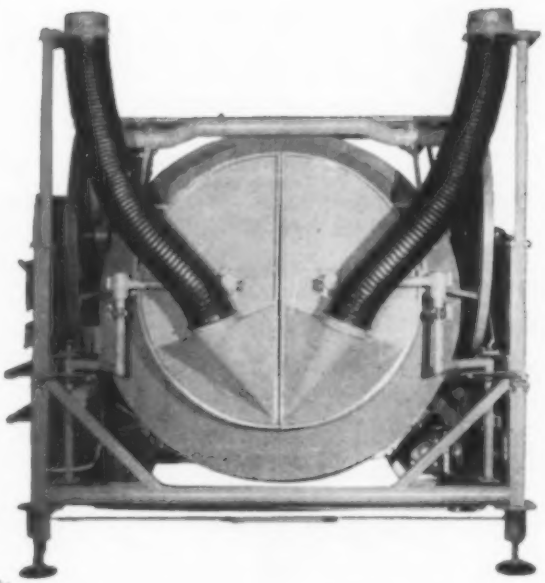
Rubber tripod feet cushion sound and prevent vibration travel. A new mobile stand available for use with the new peeler has an 18 by 20-inch top with storage shelf. **Universal Industries, Inc., 366 Mystic Ave., Somerville, Mass.**

For more details circle #888 on mailing card.

(Continued on page 210)

PURKETT'S *New 25*-ring 72-inch Pre-Drying Conditioning Tumbler

Gives 4 lbs. Moisture Removal per Minute



Provides Maximum Efficiency In Conditioning Operations

Operates with all former loading equipment. 250 lb. capacity loaded and unloaded non-stop. Unloads on opposite side from loading side for proper workflow. Saves transporting of work being processed. Goods are ready to be fed directly through the ironers or to the presses.

Purkett qualified engineers will assist you with your laundry, linen and garment conditioning problems without obligation.

Naturally it's a PURKETT®

Purkett equipment is sold by ALL Major Laundry Machinery Manufacturers and by

PURKETT MANUFACTURING COMPANY

Joplin, Missouri

DEPENDABLE PRE-DRYING CONDITIONING TUMBLERS

WHAT'S NEW

Sterile Rib-Back Blade in Autoclavable Pack

The superior carbon steel Sterile Rib-Back Bard-Parker Blade is now available in a puncture-proof, autoclavable package. The new package is easily opened, yet fully protects the sterile blade within. The

heat sealed package permits opening so that the nurse can attach the knife handle to the blade while in the opened package, thus further protecting sterility. B-P sterile packaged blades are available in all sizes in one gross boxes, in the new package and in the B-P Rack-Pack or the conventional pack. **Bard-Parker Company, Inc., Danbury, Conn.**

For more details circle #889 on mailing card.

Polished Plate Glass in Neutral Gray

Glare and brightness reduction are combined with heat absorbing advantages in the new Parallel-O-Grey Polished Plate Glass. The new glass is twin ground, assuring relative freedom from visible distortion. The lower light transmission provides comfortable eye conditions. The pleasing color and uniformity of quality assure transmission of true colors. With the new gray glass more glazing can be used in construction without the problem of excessive glare and brightness. **Libbey-Owens-Ford Glass Co., Toledo 3, Ohio.**

For more details circle #890 on mailing card.

Luv-R-Lok Luminaire Is Fully Cleanable

The Luv-R-Lok series 170 is a fluorescent lighting fixture that is 100 per cent cleanable. Individually removable louvers are locked by spring clips and instantly unlocked by finger tip pressure. Louvers and other parts are readily removable for thorough cleaning. The "all-luminous" fixture has rigid side panels held firmly to prevent bowing, with louvers extending beyond the side panels for modern appearance. The Luv-R-Lok can be installed individually or in continuous rows, surface mounted or suspended, with or without top reflectors. It is constructed of 20-gauge steel with high gloss white enamel finish. **Lighting Products Inc., Highland Park, Ill.**

For more details circle #891 on mailing card.

(Continued on page 212)

WHAT'S NEW

Metal Edge Table in Modern Styling

The new No. 912A Thin-Line table is designed to harmonize with contemporary styling. The base and column are finished in Amber Forever Cast Solid Bronze, or in any of 20 decorator colors of porcelain enamel. Cust, one-piece construction gives strength and rigidity and the long, smooth bevel and "Thin-Line" metal edge give the table a modern appearance. **The Chicago Hardware Foundry Co., North Chicago, Ill.**

For more details circle #892 on mailing card.

Larger Glass Door Facilitates Use of Blood Cabinet

The new Jewett Blood Bank storage cabinet permits quick and easy inventory of the contents through the wider, full length glass door. Adjustable revolving shelves facilitate use and removal of bottles without disturbing others. Uniform temperature is provided throughout the refrigerator by special mechanism and dual safety controls and a safety signal are

standard equipment. The new unit is available in Model No. 1 for hospitals maintaining large blood bank facilities and in Model No. 2 for smaller requirements. **The Jewett Refrigerator Co., Inc., 2 Letchworth St., Buffalo 13, N.Y.**

For more details circle #893 on mailing card.

Low-Cost Temperature Control for Individual Rooms

Zonvalve is a new thermostatically controlled valve designed for room control of temperature. The low-cost unit is made in all standard sizes and replaces the ordinary control valve on a radiator. Powered by an electric motor, it employs low-voltage wiring and operates automatically on steam and hot water heating systems. **Heat-Timer Corp., 637 Broadway, New York 12.**

For more details circle #894 on mailing card.

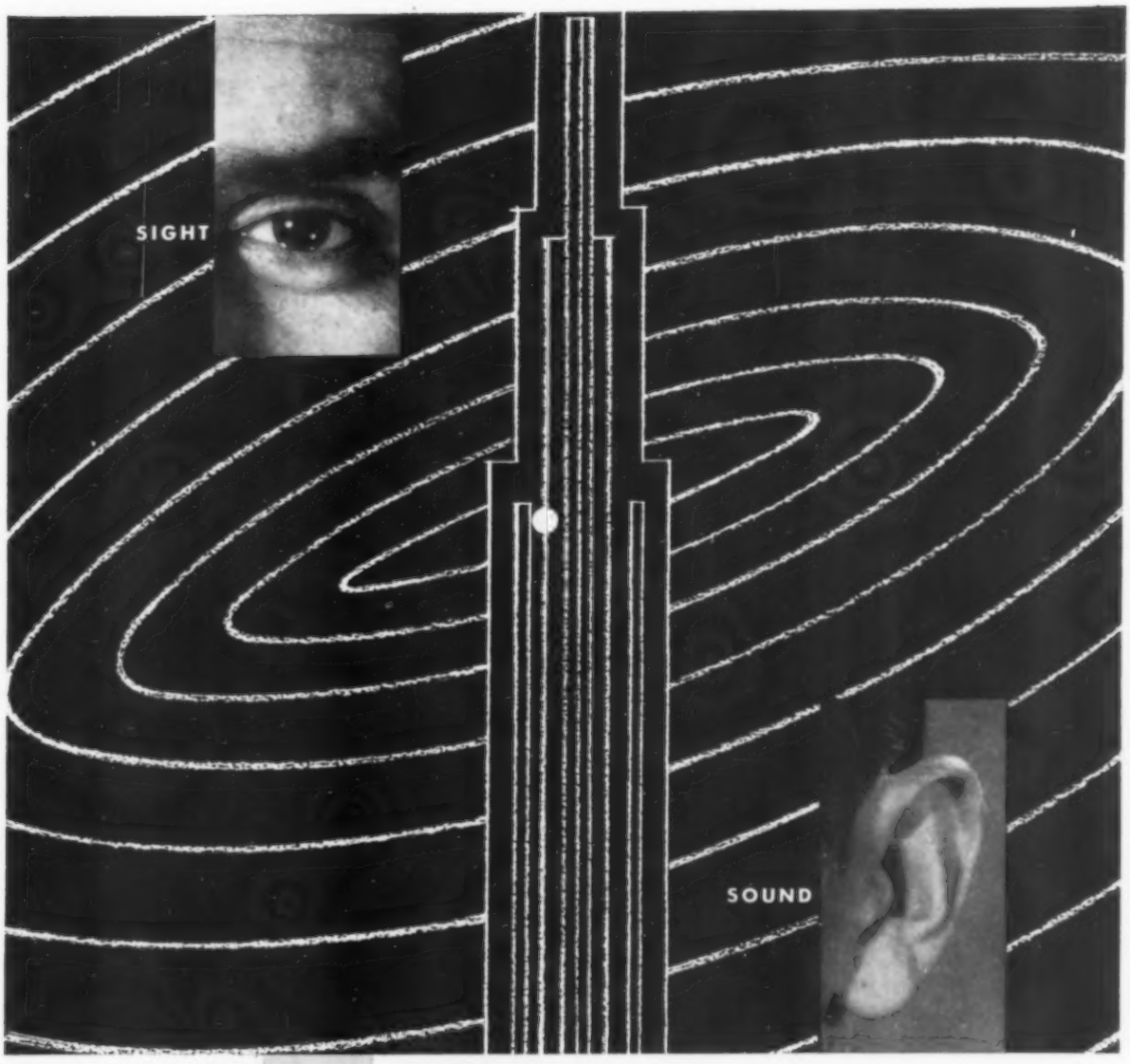
Special Hose Intake on Heavy Duty Vacuum

Model 515 is a 15-gallon vacuum cleaner with a special hose intake permitting the

use of 1¼, two and three-inch hose. The operator can thus switch from the small hose for light general cleaning to the larger hose for heavy or bulky material. Powered by a 1½ h.p. universal motor, the Model 515 features a new propeller design, increased cooling capacity, large sealed bearings and oversize carbon brushes. **Hild Floor Machine Co., Inc., 1217 W. Washington Blvd., Chicago 7.**

For more details circle #895 on mailing card.

(Continued on page 214)



our business is communications

...a gentle chime...a blasting horn...
or a complete audio-visual communication system

Specialists in:

Fire Alarm Systems
Electrical Clock Systems
Hospital Systems
Hospital Patient Observation (Closed Circuit TV)
Audible Signals
Annunciators
Coded Paging Systems
Synchronous Clocks
Transformers
Contact Devices

Sperti Faraday leads in the instant sound or sight communication systems that speed today's business or institutional contacts. Whatever your problem, whether simple or complicated our engineers are at your service to assist you in designing the system that suits your needs.

This service is available to architects without obligation. Simply call your nearest Sperti Faraday representative or write to Sperti Faraday, Inc., Adrian, Mich. In Canada, write Sperti Faraday of Canada, Ltd., Montreal.

Sperti Faraday Inc.

SINCE 1875 DESIGNERS AND PRODUCERS OF VISUAL AND AUDIBLE SIGNALS

ADRIAN, MICHIGAN

WHAT'S NEW

Prefabricated Covers for Between-Building Walkways

Low-cost, all-steel units are now available as protection to pupils and other pedestrians between buildings or sections of buildings. Consisting of standardized

units manufactured with production line economies, the prefabricated covers are quickly assembled and erected by workmen without specialized skills. Substantial savings in cost are promised with the architecturally-designed units for hospitals, schools and other institutions.

Available in widths of 4, 6, 8 and 10 feet, the walkway covers can be installed in whatever length is required. A designed-in gutter in the fascia running lengthwise of the walkway cover drains the box-V style roof sheets. Engineered for permanent installation, the covers are easily moved and re-installed and require practically no maintenance. **Childers Mfg. Co., 3620 W. 11th St., Houston 8, Texas.**

For more details circle #896 on mailing card.

Vinyl-Asbestos Floor Tile in Variety of Colors

Skytrail is the name given to a delicate wisp-like pattern for Flexachrome Vinyl-Asbestos Floor Tile. The result of months of color planning, the new design is offered in a series of decorator colors. Made of vinyl and asbestos, the tile is greaseproof, resists acids and alkalis, does not require waxing and wipes clean quickly. It can be installed over concrete slab foundation or wood sub-floors and is formulated to meet rigid requirements. Skytrail is available in nine by nine-inch size in a number of color combinations, each pattern carrying an astrological name. **The Tile-Tex Division, The Flintkote Co., 1232 McKinley Ave., Chicago Heights, Ill.**

For more details circle #897 on mailing card.

Super-Sheer Elastic Stockings in White and Black

Developed especially for nurses and Sisters, the new Super-Sheer 51 gauge Scholl Elastic Stockings are available in white and black. Constant, firm support, with greatly reduced leg fatigue and discomfort are assured with the new stockings which can be worn without overhose. The stretch nylon top makes for firm fastening and durability. The patented mitred heel anchors the stocking to prevent pull on the forepart of the foot. There are no ridges, due to design and weaving. The hose are available in small, medium and large sizes. **The Scholl Mfg. Co., Inc., 213 W. Schiller St., Chicago 10.**

For more details circle #898 on mailing card.

(Continued on page 216)

Two TV Cameras at Unusually Low Prices

Two new television cameras for closed circuit systems are now available to hospitals and other institutions at an unusually low price. The Ling Spectator is a completely self-contained unit with high light sensitivity and excellent stability which is listed at less than five hundred dollars F.O.B. Dallas, Texas. The ten-pound camera consumes little space, requires no special television monitor and can be adjusted to any practical distance range by choice of lens.

The Electron Camera Kit is an easily assembled unit listed at less than four hundred dollars in Dallas. The kit produces a ten-pound, five-tube closed circuit camera. Instructions for assembling are given in a detailed manual permitting the kit to be used as a teaching unit. Both

cameras are adapted for educational closed circuit television for teaching, monitoring and other activities. **Electron Corporation, 3512 Dyer St. Dallas, Texas.**

For more details circle #899 on mailing card.

TEAR OFF THE TOP OF THIS CAN

for important maintenance savings

Barreled Sunlight Paint Company
30-C Dudley Street, Providence 1, R. I.

☐ Sure, I'm interested in cutting costs. Contact me regarding the famous Barreled Sunlight "On-the-Wall" paint test.

☐ Send free copy of Barreled Sunlight "Engineered Color," an 18-page booklet loaded with important facts on paint and color.

Name ..... *Title* .....

Company .....

Street .....

City ..... *State* .....

You can't afford NOT to make this test!

There's only one way to figure the actual cost of paint . . . and that is *on the wall.*

Because Barreled Sunlight paint is engineered to give you more yardage, better one-coat hiding, and lower cost per square foot for both paint and labor . . . it costs less *on the wall!*

This is no idle boast . . . it is a fact proved in the field and backed by a century of specialization in heavy duty paint development.

And there's only one sound way to find out for yourself. Have a Barreled Sunlight representative demonstrate with the famous *"On-the-Wall"* test, without obligation of any kind. Tear off the top of the can and mail it today!

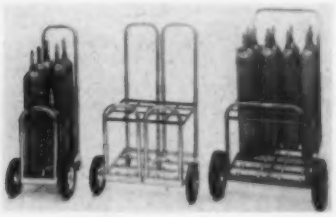
Barreled Sunlight ENGINEERED Paints

FOR A BETTER LOOKING, LONGER LASTING PAINT JOB AT LOWER COST

WHAT'S NEW

Cylinder Trucks Are Safe and Portable

The new Lumex Multiple Small Cylinder Trucks are designed primarily for transporting small anesthesia and oxygen tanks from storage to the operating or delivery room. Available in three sizes, the trucks are the first items in the new Lumex line of cylinder handling equipment. Features



of the line include safety and portability and the three sizes accommodate 6, 12 or 24 "D" or "E" sized cylinders.

Heavy gauge steel, welded for added strength and rigidity, is used in the trucks. Heavy duty Plasticol coating on the top divider rack makes for noise-free handling. Semi-pneumatic wheels and casters, grounded for static electricity, make the trucks safely mobile. **Lumex, Inc., Valley Stream, N.Y.**

For more details circle #900 on mailing card.

Vat Dyed Cotton Blankets in "Hospital Green"

Style 304 Naplite Cotton Blanket is now available in "Hospital Green." The vat dyed blanket is softly napped for smoothness and comfort. It is tightly woven and finished with firm whipped edges to withstand wear and washing. The "Hospital Green" blankets were developed by Bates especially for hospital use and can serve as a light cover, warm sheet or as an ether blanket. Naplite blankets are woven to give warmth without weight and to keep their softness, color and full size for the life of the blanket. **Bates Fabrics, Inc., 112 W. 34th St., New York 1.**

For more details circle #901 on mailing card.

Air Flow Controller for Air Conditioning Systems

The R-316 Air Flow Controller is a simple new control device designed to increase the accuracy and reduce the cost of installing and operating high velocity, double duct type air conditioning systems. Each room is supplied with a constant volume of conditioned air with the new device. It is installed in the thermostatically controlled high velocity units which mix hot and cold air in proper proportions to meet the requirements of each room. Constant volume air delivery is thus assured for each room, regardless of the number of mixing units in the system, the length of the duct or differences in pressure, according to the report.

Flexibility and economy are combined in the R-316 since savings are effected in initial fan costs, fan h.p. consumption and duct design, as well as the problem of manual balancing of the air conditioning system. **Johnson Service Co., Milwaukee 1, Wis.**

For more details circle #902 on mailing card.

Patient Records Indicated by Color Tab

Nursing and administrative time is saved by use of the new Timesaver Chart Index. Sized 8½ by 11½ inches, to fit any clipboard or chartbook, the index consists of nine separate sheets per set, 50 sets to the box. Each section is identified by a color-coded tab which quickly locates the

required record. Included are doctors orders, admittance record, graphic chart, nurses', physical exam, operating, laboratory, pathology, x-ray, E.K.G., progress and narcotic records. **Hospitex Co., 10433 Burbank Blvd., North Hollywood, Calif.**

For more details circle #903 on mailing card.

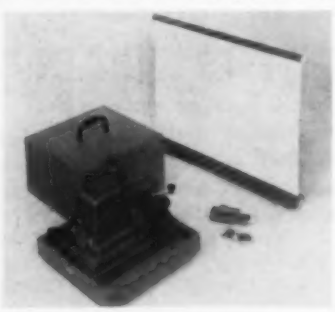
No-Corrode Tablets Protect Fuel Tanks

Fuel oil and other storage tanks can now be protected from rust with the new Sexauer Tank No-Corrode tablets. They are designed to neutralize sulphur acids formed when water condensation is trapped, stopping electrolysis and corrosion, preventing leaks and prolonging tank life. It does not float or clog lines or filters, and does not dissolve or react in oil. **J. A. Sexauer Mfg. Co., Inc., 2503 Third Ave., New York 51.**

For more details circle #904 on mailing card.

Projector-Viewer for Diagnostic Films

Diagnostic clarity is provided for films shown in the new Micro Projector-Viewer.



Designed especially for hospital use, the new 35mm, 500-watt projector shows details of medical specimens and x-ray film. It will show roll film, filmstrips or two by two-inch slides interchangeably. The unique cooling system is designed to permit the projection of even a cardboard mounted slide for long periods without buckling. **Micro X-Ray Recorder, 3755 W. Lawrence Ave., Chicago 25.**

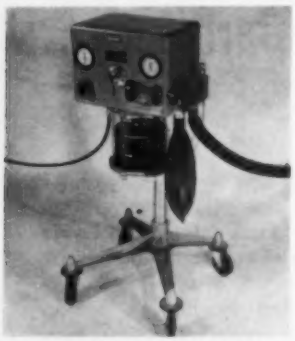
For more details circle #905 on mailing card.

(Continued on page 218)

WHAT'S NEW

Anesthesia Assister Is Fully Controlled

Controlled respiration during anesthesia is provided with the new Bennett Assister. The instrument permits the anesthetist the option of fully-controlled, assisted, partially-assisted, patient-controlled or manually-controlled respiration. Manual control is



quickly accomplished by fingertip action of the Bennett Valve or squeezing of the bag. Oxygen or compressed air powers the unit which is pneumatically operated to eliminate electrical hazard. **Bennett Respiration Products, 2230 S. Barrington Ave., Los Angeles 64, Calif.**

For more details cicrle #906 on mailing card.

Melmac Dinnerware in Color-on-Color Design

An exclusive color-on-color process which bonds two colors into a single piece is used to produce the new DeLuxe Regal Ware Melmac dinnerware. The new pattern incorporates the Texas-Ware self-draining contour base and heavy-duty rolled edge for appearance and strength. The new ware is available in sepia and tan, white with burgundy, Bermuda coral and sage green, and in solid and textured colors. **Plastics Mfg. Co., 825 Trunk Ave., Dallas 10, Texas.**

For more details circle #907 on mailing card.

Self-Closing Waste Receptacle Has Stainless Steel Door

A chrome plated top fitted with a stainless steel door is a feature of the new No. 1001 Torpedo Receptacle. Occupying minimum space, the waste container is attractive in appearance and easy to maintain. It is available finished in white, red, gray or olive green baked enamel with stainless steel trim. A rubber door silencer makes it quiet in operation and the rounded top and sides are easy to clean. **The F. H. Lawson Co., Cincinnati 4, Ohio.**

For more details circle #908 on mailing card.

Glove Powdering Conditioner for Small Loads

The Medisco Glove Powdering Conditioner is designed for use in small hospitals up to approximately 50 beds. Made of gray enameled steel, it has a transparent plastic cover permitting full visibility during the powdering procedure. It is entirely dust-free and has hand openings four inches in diameter. Users hands are inserted through tubular stockinette which is easily removed for cleaning. The Medisco is 20 by 12 by 12 inches in size. **Medisco Inc., 155 W. 72nd St., New York 23.**

For more details circle #909 on mailing card.

(Continued on page 220)

WHAT'S NEW

Pharmaceuticals

Medrol

Medrol is a new synthetic corticosteroid hormone with high potency and minimum tendency to produce undesirable side effects. The new steroid is a derivative of prednisolone and is indicated in the treatment of rheumatic diseases, allergic diseases, generalized dermatoses with an allergic component, acute occular inflammatory disease and other diseases responsive to anti-inflammatory corticosteroids. Medrol causes minimum sodium and fluid retention, practically eliminating the hazard of edema, and epigastric distress occurs only rarely with Medrol. Medrol is a white, odorless, crystalline compound and is supplied in 4 mg. scored tablets, in bottles of 30 and 100. **The Upjohn Company, Kalamazoo, Mich.**

For more details circle #910 on mailing card.

Tussionex Tablets and Liquid

Tussionex is a controlled "Strasionic" release antitussive. Tussionex releases the antitussive dihydrocodeinone and the antihistaminic phenyltoloxamine through dynamic ionic exchange from their resin complexes to sustain the action of both for eight to twelve hours. Tussionex is available in two forms, tablets and liquid suspension. The tablets, brown, scored, are supplied in bottles of 100. Tussionex Liquid Suspension is a pleasant tasting golden colored compound supplied in pint bottles. **R. J. Strasenburgh Co., 195 Exchange St., Rochester 4, N.Y.**

For more details circle #911 on mailing card.

Concentrated Gamma Globulins

More concentrated dosage forms of the two Hyland specific gamma globulin specialties for prevention and treatment of mumps and whooping cough are now available. Smaller dosage is possible with the greater concentration of antibodies in the new products. The more concentrated products have been renamed. Mumps Immune Globulin (Human) replacing Antimumps Serum (Human) Concentrated, is supplied in 1.5 cc and 4.5 cc vials. Pertussis Immune Globulin (Human), replacing Antipertussis Serum (Human) Concentrated, is supplied in 1.5 cc vials. Both new products are in liquid form, ready for immediate injection. **Hyland Laboratories, 4501 Colorado Blvd., Los Angeles 39, Calif.**

For more details circle #912 on mailing card.

Ritalin Injectable

An injectable form of Ritalin is now available for use in oral surgery, respiratory depression and in psychiatric treatment. Ritalin Injectable, parenterally administered, gives speed of action and raises the severely lowered blood pressure of patients suffering from acute overdosage of barbiturates. A nonamphetamine, Ritalin Injectable produces immediate central stimulation. Orally administered, Ritalin has little or no effect on blood pressure. The new product can be given intravenously, intramuscularly or subcutaneously. **Ciba Pharmaceutical Products Inc., 556 Morris Ave., Summit, N.J.**

For more details circle #913 on mailing card.

Literature and Services

• A 28-page manual, **"How to Measure Your Filing Costs and Efficiency,"** is available from Remington Rand, Division of Sperry Rand Corp., 315 Fourth Ave., New York 10. In addition to handy guides for measuring filing costs and results, the manual gives a detailed plan of action to improve filing efficiency.

For more details circle #914 on mailing card.

• A bibliography prepared by Eastman Kodak Research Laboratories on the subject of Microradiography and Soft X-Ray Radiography is an important part of a new 48-page book entitled **"Principles of Microradiography"** published by the Instruments Division, Philips Electronics, Inc., 750 S. Fulton Ave., Mount Vernon, N.Y. Nearly 500 references are listed in the bibliography, which follows the text section.

For more details circle #915 on mailing card.

• **"Sanborn Instruments for Biophysical Research"** are the subject of a new catalog released by Sanborn Co., Medical Division, 175 Wyman St., Waltham 54, Mass. The 28-page booklet describes all Sanborn recording equipment, monitoring oscilloscopes, related equipment, and transducers of interest to those concerned with measurement, recording and study of physiological phenomena.

For more details circle #916 on mailing card.

• A new **Bake-Wip Formula Booklet** is now available from Bake-Wip Division, 8025 Melrose Ave., Los Angeles 46, Calif. In the formula booklet are 33 tested formulas for dessert fillings, icings and toppings, as well as sandwich spreads and salad dressings which can be whipped up in a hurry with Bake-Wip. Bake-Wip is a sterilized product requiring no refrigeration which does not shrink, weep, discolor or form a crust.

For more details circle #917 on mailing card.

• The complete line of **self-sticking Time Tapes and Labels** is covered in a new 12-page catalog offered to hospitals, clinics and laboratories by Professional Tape Co., Inc., 357 E. Burlington Ave., Riverside, Ill. Over 500 categories are listed for central service, operating and solution rooms, pharmacy, laboratory, nursing, blood bank and special labels.

For more details circle #918 on mailing card.

• A new catalog of **Radioisotope Equipment for Medical Use** is now available from the Technical Publications Dept., Tracerlab, Inc., 1601 Trapelo Road, Waltham 54, Mass. The 32-page booklet contains data of interest to those concerned with the clinical use of radiochemicals for any purpose. The method of presentation makes it possible to tell at a glance the instruments required for any standard technic.

For more details circle #919 on mailing card.

• The attractive line of modern **Skandia Furniture** is shown and described in a new brochure available from Superior Sleeprite Corp., 759 S. Washtenaw Ave., Chicago 12. Patient room, nurse's room and lounge furniture is included in the line.

For more details circle #920 on mailing card.

(Continued on page 222)

WHAT'S NEW

• The new **Angelica Catalog of Hospital Apparel** is now off the presses. Uniforms for all personnel in all departments of the hospital are included in the new booklet available from Angelica Uniform Co., 1427 Olive St., St. Louis 3, Mo. Patients and operating room apparel of Xtra-Duty Cloth, a medium weight durable, yet soft and comfortable sheeting, are introduced through the catalog as are other items of apparel for patients and personnel. The new catalog is a comprehensive reference guide for hospital apparel.

For more details circle #921 on mailing card.

• **Shadowal Concrete Masonry Block** is the subject of an attractively printed 12-page brochure released by the National Concrete Masonry Assn., 38 S. Dearborn St., Chicago 3. Described as "the block with 1000 faces," Shadowal Block is shown by itself and in interesting installations in a series of attractive black and white sketches.

For more details circle #922 on mailing card.

• **"So You're Going to Raise Funds"** is the title of a new 55-page guide to the principles and technics of fund raising published by the National Publicity Council, 257 Fourth Ave., New York 10. It was written for use by all organizations who must raise funds from the public: colleges, schools, hospitals and similar groups. Individual copies are available from the Council at $1.25 each, plus five cents postage, with discounts on quantities.

For more details circle #923 on mailing card.

• A new **Sterilization Chart** issued by The Pioneer Rubber Co., 396 Tiffin Road, Willard, Ohio, describes an improved method of sterilizing surgical gloves. The nine important steps of glove care are described and illustrated on the 8½ by 11-inch card which points out that proper care, cleaning and storage ensure longer life for surgical gloves and savings to hospitals.

For more details circle #924 on mailing card.

• A new four-page catalog sheet on the **Model PD-500 Closed-Circuit Television Camera** manufactured by General Precision Laboratory, 63 Bedford Rd., Pleasantville, N.Y., is now available. Information includes features of the new camera with full description of the design characteristics, built-in power supply and accessories for complete remote operation. Detailed specifications and dimensions are given.

For more details circle #925 on mailing card.

• "The New Duo-Washfountains" described as "the greatest advance in modern sanitary wash fixtures," are presented in **Bulletin K-1204** released by Bradley Washfountain Co., Milwaukee 1, Wis. Words and pictures are used to present the new features of the unit. These include easy wall mounting, floor clearance and the wide hinged foot-treadle for control of the water supply.

For more details circle #926 on mailing card.

• A new 20-page manual gives full technical information on the **Geyser Grid System** for curtain walls and windows. Released by E. K. Geyser Co., 915 McArdle Roadway, Pittsburgh 3, Pa., the manual contains detailed diagrammatic drawings of the system and its uses, together with recommendations of how to design economically with the Geyser System.

For more details circle #927 on mailing card.

• A new short form **catalog, YSI-50-1257**, is now available from Yellow Springs Instrument Co., P.O. Box 106, Yellow Springs, Ohio. The four-page brochure gives descriptive information on the complete line of remote indicating thermometers, thermistor probes and temperature controllers manufactured by the company.

For more details circle #928 on mailing card.

• **"Facts About the Economics of Laboratory Glassware"** are presented in a 16-page booklet prepared by Doerr Glass Co., Vineland, N.J. The information is presented with a light touch and amusing sketches, making the interesting and helpful facts easy to digest.

For more details circle #929 on mailing card.

• **"Stran-Steel Curtain Wall Panels . . Complete Structural Systems"** are the subject of a new 24-page catalog released by Stran-Steel Corp., Unit of National Steel Corp., Detroit 29, Mich. The new wide-flange shapes added to the line of steel architectural products manufactured by the company are presented in the new catalog. Diagrammatic drawings, installation photographs, specifications and other technical information relative to the line are included in the booklet.

For more details circle #930 on mailing card.

(Continued on page 224)

WHAT'S NEW

• The operation of Powermaster packaged automatic boilers is the subject of a six-page **Bulletin #1241** issued by Orr & Sembower, Inc., Morgantown Road, Reading, Pa. Operating features of these completely self-contained, automatic units are described with ratings, dimensions, weights and other data.

For more details circle #931 on mailing card.

• **A Parenteral Solution Administration Chart** in convenient pocket size is now available from Amsco Hospital Liquids, a subsidiary of the American Sterilizer Co., Erie, Pa. The chart is based on the standard I.V. set calibration of ten drops per one cc, and gives the number of drops per minute needed to administer routine amounts of solution within prescribed times. Maximum utilization rates for Dextrose and Invert Sugar and Alcohol are included, together with basic precautions to be observed in fluid therapy. The chart is designated as **F-5125-MH.**

For more details circle #932 on mailing card.

• **Catalog No. 58** is a 52-page booklet covering the full line of Craftool tools, equipment and furniture for ceramic and graphic arts shops. Designed especially for occupational therapy and other teachers and craftsmen, the new catalog presents descriptive text and illustrations of the many items of tools and equipment available from Craftools, Inc., 396 Broadway, New York 13.

For more details circle #933 on mailing card.

Book Announcement

Beckman, "Drugs, Their Nature, Action and Use," 728 pp., $15. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #934 on mailing card.

Suppliers' News

The American Can Co., 100 Park Ave., New York 7, announces the formation of a **Dixie Cup Division** to handle the operations of the former Dixie Cup Company, merged into the can company last year. **Dixie Cup Division** general offices will remain at **Easton, Pa.,** and **C. L. Van Schaick,** former Dixie president and now Canco vice president, is now vice president and general manager of the **Dixie Cup Division.**

Becton, Dickinson & Co., Rutherford, N.J., manufacturer of medical and surgical products, announces a new shipping system to speed delivery of its products to hospitals and distributors. The new service makes such B-D products as thermometers, hypodermic needles, syringes and other instruments available anywhere in the United States within five days of shipment. The new policy ensures more rapid deliveries, greater control over shipments and facilitates checking and tracing of orders.

• **B. F. Goodrich Industrial Products Co., Coated Fabrics Div., Marietta, Ohio,** announces the completion of arrangements for branches of **Sherwin-Williams Co., 101 Prospect Ave., N.W., Cleveland 1, Ohio,** manufacturer of paint products, to market Koroseal vinyl wall covering in all principal marketing areas in the nation. The wall covering, manufactured by Goodrich, has an abrasion resistant surface which does not show scratches or scuffs, is not harmed by grease, food, oil, alcohol, alkalis or acids, and keeps its colorful state by washing with a damp cloth.

Huntington Laboratories, Inc., Huntington, Ind., manufacturer of maintenance equipment and supplies, announces that **Spal Concentrate Detergent** has been listed by **Underwriters Laboratories** as a safe cleaner for conductive floors. Spal is part of the company's complete maintenance program for conductive floors which includes Huntington C-2C Conductive Wax, previously listed by Underwriters Laboratories as safe on electrically conductive floors.

National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11, announces major changes in its organizational structure. The firm's diversified activities are being realigned into seven divisions, each with its own president and operating organization. The medical gases, inhalation therapy equipment and oxygen piping sales and service will be included in the **Chicago NCG Division. J. L. Adank** has been named president of the division with **Fred C. Heppel** as executive vice president.

Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis., manufacturer of medical gases and other hospital products, announces acquisition of the franchise to distribute in the United States and Canada the electronic cardiological equipment manufactured by **Dallons Laboratories, Inc. of Los Angeles.** The products include the Dallons Cardioscope, Cardiophone and Defibrillator and have a direct relationship to the present line of anesthetic gases, anesthesia machines, therapy oxygen, resuscitators and sutures manufactured by Ohio.

Formation of **Shampaine Industries, 1920 S. Jefferson, St. Louis 4, Mo.,** through the consolidation of nine previously separate companies is announced by **H. R. Shampaine,** president. Manufacturers and distributors of hospital, medical and dental equipment and supplies, **Shampaine Industries** is a management unit responsible for operations of the member companies: **Shampaine Co., St. Louis; Shampaine Electric Co., New Rochelle, N.Y.; W. D. Allison Co., Indianapolis; Carrom Industries, Inc., Ludington, Mich.; Richard Philip Co., St. Louis; Professional Specialties, Inc., St. Louis; Crown Products, Inc., St. Louis; Harley Corp., Memphis, Tenn., and O.E.M. Corp., East Norwalk, Conn.** Each of the member companies will retain its own identity.

United States Bronze Sign Co., Inc., manufacturer of bronze, stainless steel, aluminum, porcelain enamel iron, galvaneal and plastic signs, plaques, memorials, building letters, bulletin boards, nameplates, and similar products, announces removal of its executive and sales offices to larger quarters at **101 W. 31st St., New York 1.** Production will continue at the modern plant and foundry at Woodside, N.Y.

INDEX TO "WHAT'S NEW

Pages 189-224

Key

851 Model FS 100 Food Assembly Unit
The Swartzbaugh Mfg. Co.

852 Custom Minaboard
Armstrong Cork Co.

853 Sterling Baumanometer Base
W. A. Baum Co. Inc.

854 Cobalt 60 Therapy Unit
Westinghouse Electric Corp.

855 Nibroc Colored Towels
Brown Co.

856 Selectric Push Button Mattress
Doyle Products Co.

857 BFOT Baseboard
Dunham-Bush, Inc.

858 Foley Bag Catheter
General Hospital Industries

859 Stirrup Bracket
Sanymetal Products Co., Inc.

860 Portable Air Conditioner
Carrier Corp.

861 "Sani-Vat" Dye Kit
American Aniline Products

862 Tray Dispenser
W. H. Frick, Inc.

863 Sterwelopes
Stanley Supply Co., Inc.

864 Wide Stile Door
Kawneer Co.

865 All-Purpose Detergent
Kellite Corp.

866 Comfortaire Cushion
The Art Neth Co.

867 PowerPak 582
Wilmot Castle Co.

868 Negastat Solution
Functional Products

869 Three-Piece Battery
Ancora Corp.

870 Shower Valve
Lawler Automatic Controls, Inc.

871 Cup Dispensing Tray
Lily-Tulip Cup Corp.

872 Narcotic Control Cabinet and Dispenser
American Hospital Supply Corp.

873 Eye-Comfort Troffers
Curtis Lighting, Inc.

874 Light & Vision Institute
Holophane Co., Inc.

875 Nurses' Station Unit
McKesson & Robbins, Inc.

876 "Mr. Bones"
V. Mueller & Co.

877 Dual Foldout Partition
Holcomb & Hoke Mfg. Co., Inc.

878 Mobile Ice Chest
Nutting Truck & Caster Co.

879 Record Racks
Acme Visible Records, Inc.

Key

880 Televiewer
The Dahlberg Co.

881 Nebulizer-Humidifier
Continental Hospital Industries

882 Universal Arm Board
Sierra Engineering Co.

883 "Easy Opener" Package
General Mills, Inc.

884 Floor Dressing
Masury-Young Co.

885 Automatic Partitions
Dubuque Products Inc.

886 Logstat
Walter G. Legge Co.

887 Hydrojette
Air-Shields, Inc.

888 Portable Peeler
Universal Industries, Inc.

889 Rib-Back Blade
Bard-Parker Co., Inc.

890 Polished Plate Glass
Libbey-Owens-Ford Glass Co.

891 Series 170 Luminaire
Lighting Products, Inc.

892 Thin-Line Table
The Chicago Hardware Foundry Co.

893 Blood Banks
The Jewett Refrigerator Co., Inc.

894 Temperature Control
Heat-Timer Corp.

895 Model 515 Vacuum
Hild Floor Machine Co., Inc.

896 Multiple Small Cylinder Trucks
Lamex, Inc.

897 "Hospital Green" Blanket
Bates Fabrics, Inc.

898 R-816 Air Flow Controller
Johnson Service Co.

899 Timesaver Chart Index
Hospitex Co.

900 Tank No-Corrode Tablets
J. A. Sexauer Mfg. Co., Inc.

901 500-Watt Projector-Viewer
Micro X-Ray Recorder

902 Bennett Assister
V. Ray Bennett & Associates, Inc.

903 Regal Dinnerware
Plastic Mfg. Co.

904 Waste Receptacle
F. H. Lawson Co.

905 Glove Powdering Conditioner
Medisco Inc.

906 Prefabricated Walkways
Childers Mfg. Co.

907 Floor Tile
The Filtrorow Co.

Key

908 Elastic Stockings
Dr. Scholl's

909 Limp Spectator and Electron Camer
Electron Corp.

910 Medrol
Upjohn Co.

911 Tussionex Tablets and Liquid
R. J. Strassenburgh Co.

912 Mumps and Pertussis Immune Glo
Hyland Laboratories

913 Ritalin Injectable
Ciba Pharmaceutical Products

914 "How to Measure Filing Costs"
Remington Rand

915 "Principles of Microradiography"
Philippe Electronics, Inc.

916 "Instruments for Biophysical Rese
Sanborn Co.

917 Formula Booklet
Bake-Wip Div.

918 Time Tapes and Labels
Professional Tape Co.

919 Radioisotope Equipment Catalog
Trucerlab, Inc.

920 Skandia Furniture Brochure
Superior Sleeprite Corp.

921 Hospital Apparel Catalog
Angelica Uniform Co.

922 Shadowal Block
National Concrete Masonry As

923 "So You're Going to Raise Funds"
National Publicity Council for
& Welfare Services, Inc.

924 "How to Sterilize Surgical Gloves"
The Pioneer Rubber Co.

925 Model PD-500 Camera Catalog
General Precision Laboratory

926 Duo-Washfountain Catalog
Bradley Washfountain Co.

927 "Curtain Walls—Windows"
E. L. Geyser Co.

928 Catalog YSI-50-1257
Yellow Springs Instrument Co.

929 "Facts About the Economics of
Laboratory Glassware"
Doerr Glass Co.

930 Structural Systems Catalog
Stran-Steel Corp.

931 Chart F-5125-MH
American Sterilizer Co.

932 Bulletin #1241
Orr & Sembower, Inc.

933 Catalog No. 58
Craftools, Inc.

934 "Drugs"
W. B. Saunders Co.

USE THESE CARDS

(We pay the postage)

I am interested in the items circled— March, 19

WHAT'S NEW						ADVERTISEMENT										
851	852	853	854	855	856	1	2	3	4	5	6	7	8	9	10	11
857	858	859	860	861	862	14	15	16	17	18	19	20	21	22	23	24
863	864	865	866	867	868	27	28	29	30	31	32	33	34	35	36	37
869	870	871	872	873	874	40	41	42	43	44	45	46	47	48	49	50
875	876	877	878	879	880	53	54	55	56	57	58	59	60	61	62	63
881	882	883	884	885	886	66	67	68	69	70	71	72	73	74	75	76
887	888	889	890	891	892	79	80	81	82	83	84	85	86	87	88	89
893	894	895	896	897	898	92	93	94	95	96	97	98	99	100	101	102
899	900	901	902	903	904	105	106	107	108	109	110	111	112	113	114	115
905	906	907	908	909	910	118	119	120	121	122	123	124	125	126	127	128
911	912	913	914	915	916	131	132	133	134	135	136	137	138	139	140	141
917	918	919	920	921	922	144	145	146	147	148	149	150	151	152	153	154
923	924	925	926	927	928	157	158	159	160	161	162	163	164	165	166	167
929	930	931	932	933	934	170	171	172	173	174	175	176	177	178	179	180

NAME TITLE

INSTITUTION

ADDRESS CITY ZONE STATE

EW"

Electron Camera Eq

and Liquid
ugh Co.
ale Immune Globulin
thories

utical Products Inc.
Filing Costs"
nd
roradiography"
onics, Inc.
liophysical Research"

abels
ape Co.
ment Catalog

Brochure
rite Corp.
Catalog
rm Co.

ete Masonry Assn.
o Raise Funds"
city Council for Health
ervices, Inc.
Surgical Gloves"
bber Co.
era Catalog
ion Laboratory
Catalog
ountain Co.
Windows"
o.
Instrument Co.
conomics of
eware"
Catalog
p.
ller Co.
ic., Inc.
Co.

INDEX TO ADVERTISEMENTS ON FOLLOWING PAGE

TO REQUEST PRODUCT INFORMATION
FOLD THIS FLAP OUT
AND USE THESE CARDS

(We pay the postage)

The two cards below are detachable and are addressed to us. With this flap folded out you can turn through the magazine for the items on which you want further information.

When, in either an advertisement or "What's New" you locate the product, turn to the index to advertisements on the following page or to the index of "What's New" items (left) where you will find the key number for the item. Items advertised are listed alphabetically by manufacturer. "What's New" items are in Key Number order. Circle the corresponding key number on the card below for each item in which you are interested. The second card is for the use of someone else who may also want product data.

Detach and mail — no postage required.

March, 1958 (b)

9	10	11	12	13
22	23	24	25	26
35	36	37	38	39
48	49	50	51	52
61	62	63	64	65
74	75	76	77	78
87	88	89	90	91
100	101	102	103	104
113	114	115	116	117
126	127	128	129	130
139	140	141	142	143
152	153	154	155	156
165	166	167	168	169
178	179	180	181	182

I am interested in the items circled—

March, 1958 (a)

WHAT'S NEW					
851	852	853	854	855	856
857	858	859	860	861	862
863	864	865	866	867	868
869	870	871	872	873	874
875	876	877	878	879	880
881	882	883	884	885	886
887	888	889	890	891	892
893	894	895	896	897	898
899	900	901	902	903	904
905	906	907	908	909	910
911	912	913	914	915	916
917	918	919	920	921	922
923	924	925	926	927	928
929	930	931	932	933	934

ADVERTISEMENT													
1	2	3	4	5	6	7	8	9	10	11	12	13	
14	15	16	17	18	19	20	21	22	23	24	25	26	
27	28	29	30	31	32	33	34	35	36	37	38	39	
40	41	42	43	44	45	46	47	48	49	50	51	52	
53	54	55	56	57	58	59	60	61	62	63	64	65	
66	67	68	69	70	71	72	73	74	75	76	77	78	
79	80	81	82	83	84	85	86	87	88	89	90	91	
92	93	94	95	96	97	98	99	100	101	102	103	104	
105	106	107	108	109	110	111	112	113	114	115	116	117	
118	119	120	121	122	123	124	125	126	127	128	129	130	
131	132	133	134	135	136	137	138	139	140	141	142	143	
144	145	146	147	148	149	150	151	152	153	154	155	156	
157	158	159	160	161	162	163	164	165	166	167	168	169	
170	171	172	173	174	175	176	177	178	179	180	181	182	

TITLE

STATE

NAME TITLE

INSTITUTION

ADDRESS CITY ZONE STATE

+ + + INDEX TO ADV

Key		Page
1	Abbott Laboratories	following page 138
2	Acme Visible Records, Inc. (HPF)	107
3	Adams & Westlake Company (HPF)	46
4	Admiral Corporation (HPF)	101
5	Air-Shields, Inc. (HPF)	44, 45
6	Aloe Company, A. S. (HPF)	following page 32
7	American Cyanamid Company, Surgical Products Division (HPF)	107
8	American Cystoscope Makers, Inc.	133
9	American Hospital Supply Corporation (HPF)	106, 107
10	American Laundry Machinery Company (HPF)	30, 31
11	American Machine & Metals, Inc.	119
12	American Sterilizer Company (HPF)	11
13	American Sterilizer Company (HPF)	105
14	Anemostat Corporation of America	170, 171
15	Angelica Uniform Company	164
16	Anaco Corporation	following page 32
17	Applegate Chemical Company (HPF)	128
18	Appleton Electric Company	150
19	Armstrong Company, Inc., Gordon (HPF)	206
20	Aseptic-Thermo Indicator Company	218
21	Auth Electric Company, Inc.	20
22	Baker Linen Company, H. W.	200
23	Bard, Inc., C. R.	155
24	Bard-Parker Company, Inc. (HPF)	41
25	Bard-Parker Company, Inc. (HPF)	100
26	Barnstead Still & Sterilizer Co. (HPF)	12
27	Barnstead Still & Sterilizer Co. (HPF)	161
28	Barreled Sunlight Paint Company	215
29	Bassick Company (HPF)	223
30	Bates Fabrics, Inc.	183
31	Bay West Paper Company	154
32	Beck-Lee Corporation	148
33	Becton, Dickinson & Company (HPF)	147
34	Berbecker & Sons, Inc., Julius (HPF)	218
35	Blickman, Inc., S. (HPF)	113
36	Bristol Laboratories Inc.	42, 43
37	Brown Company	48
38	Carrier Corporation	38, 39
39	Carrier Corporation	207
40	Carrom Industries, Inc. (HPF)	137
41	Castle Company, Wilmot (HPF)	following page 32
42	Caterpillar Tractor Company	9
43	Chicago Hardware Foundry Company	24
44	Clarke Sanding Machine Company (HPF)	14
45	Classified Advertising	173-184
46	Colgate-Palmolive Company	141
47	Colson Corporation (HPF)	108
48	Continental Coffee Company	6
49	Corning Glass Works	35
50	Crane Company	15
51	Custom Food Products, Inc.	195
52	Deknatel & Son, Inc., J. A.	32
53	De Puy Mfg. Company, Inc.	154
54	Dewey & Almy Chemical Company Division of W. R. Grace & Co.	8
55	Diack Controls (HPF)	10
183	Dodge Corporation, F. W.	223
56	Dolge Company, C. B.	202
57	Eastman Kodak Company	following page 160
58	Eichenlaubs	222
59	Elgin Softener Corporation (HPF)	205
60	Everest & Jennings	146
61	Executone, Inc.	201
62	Fairbanks, Morse & Company	194
63	Finnell System, Inc. (HPF)	117
64	Fleet Company, Inc., C. B. (HPF)	181
65	Flex-Straw Corporation (HPF)	153
66	Fort Howard Paper Company	149
67	Franklin Products Corp.	195
68	Gaychrome Company	182
69	Georgeee Wringer, Inc.	202
70	General Bronze Corporation	157
71	General Electric Company, X-Ray Department (HPF)	26, 27
72	General Tire & Rubber Company	178
73	Gennett & Sons, Inc.	214
74	Glasco Products Company (HPF)	206
75	Glynn-Johnson Corporation (HPF)	188
76	Goodrich Industrial Products Company, B. F.	172
77	Goodrich Sponge Products, B. F.	193
78	Grand Rapids Section Co. (HPF)	
79	Grant Pulley & Hardw	
80	Grocery Store Produc	
81	Gruendler Crusher &	
82	Hall China Company,	
83	Hampden Specialty P	
84	Hanovia Lamp Divisio Industries, Inc. (H	
85	Harold Supply Corpo	
86	Hausted Mfg. Compan	
87	Heal-Lite Company	
88	Heinz Company, H. J.	
89	Herrick Refrigerator C	
90	Hill-Rom Company, In	
91	Hillyard Chemical Co	
92	Holcomb & Hoke Manu Company, Inc.	
93	Hollister Company, Fr	
94	Huntington Laboratori (HPF)	
95	Huntington Laboratori (HPF)	
96	Ille Electric Corporatio	
97	Indian Head Mills, Inc	
98	International Bronze T	
99	Jarvis & Jarvis, Inc. (H	
100	Jewett Refrigerator Co (HPF)	
101	Johnson & Johnson	
102	Keyes Fibre Company	
103	Koenigkramer Compan	
104	Kohler Company	
105	Landers, Frary & Clark	
106	Legge Company, Inc., (HPF)	
107	Lilly & Company, Eli	
108	Lily-Tulip Cup Corpora	
109	Linde Company, Divisi Carbide Corp. (HPF	
110	Liquid Carbonic Corpo	
111	Low X-Ray Corporation	
112	McKesson Appliance C	

FIRST CLASS
PERMIT NO. 137
SEC. 34.9 P. L. & R.
CHICAGO, ILL.

BUSINESS REPLY CARD
No Postage Stamp Necessary If Mailed in the United States

3 CENT POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL

919 NORTH MICHIGAN AVENUE

CHICAGO 11, ILLINOIS

DVERTISEMENTS

	Page
Rapids Sectional Equipment (HPF)	142
Pulley & Hardware Corporation	221
Store Products Company	112
dler Crusher & Pulverizer Co.	219
China Company	Cover 3
den Specialty Products, Inc.	182
ria Lamp Division of Engelhard dustries, Inc. (HPF)	84
Supply Corporation	222
od Mfg. Company (HPF)	1
ite Company	180
Company, H. J.	111
k Refrigerator Company (HPF)	204
on Company, Inc. (HPF)	156
rd Chemical Company (HPF)	18, 19
nb & Hoke Manufacturing mpany, Inc.	190
er Company, Franklin C.	following page 18
gton Laboratories, Inc. PF)	130, 131
gton Laboratories, Inc. PF)	224
ectric Corporation	facing page 177
Head Mills, Inc.	13
ational Bronze Tablet Co., Inc.	138
& Jarvis, Inc. (HPF)	158
Refrigerator Company, Inc. PF)	198
n & Johnson	following page 82
Fibre Company	following page 16
kramer Company, F & F	182
Company	170
s. Frary & Clark	220
Company, Inc., Walter G. PF)	118
Company, Eli	8
lip Cup Corporation (HPF)	115
Company, Division of Union rbide Corp. (HPF)	203
Carbonic Corporation	189
-Ray Corporation	185
on Appliance Company	135

Key		Page
113	MacRick Company (HPF)	98
114	Mastic Tile Corporation of America	193
115	Mealpack Corporation (HPF)	7
116	Meals-on-Wheels System (HPF)	140
117	Medipoint Inc.	144
118	Minnesota Mining & Mfg. Company	210
119	Moore, Inc., P. O.	223
120	Multi-Clean Products, Inc.	197
121	Naico Corporation (HPF)	175
122	Nelson Company, Inc., A. R. (HPF)	211
123	Norton Door Closer Company (HPF)	177
124	O. R. M. Corporation (HPF)	21
125	Ohio Chemical & Surgical Equipment Company (HPF)	150, 151
126	Onan & Sons, Inc., D. W. (HPF)	122
127	Parke, Davis & Company	103
128	Patton Hall, Inc.	234
129	Peck's Products Company	148
130	Pharmaseal Laboratories	following page 144
131	Physicians' Record Company (HPF)	166
132	Picker X-Ray Corporation (HPF)	17
133	Pioneer Rubber Company (HPF)	following page 16
134	Pratt & Lambert, Inc.	121
135	Puffer-Hubbard Refrigerator Co.	198
136	Puritan Compressed Gas Corp.	40
137	Purkett Manufacturing Company	200
138	Putnam's Son, G. P.	214
139	Quicap Company, Inc.	190
140	Ross, Inc., Will	37
141	Royal Lace Paper Works, Inc.	100
142	Royal McBee Corporation	183
143	Royal Metal Mfg. Company (HPF)	Cover 2
144	Savory Equipment Inc. (HPF)	212
145	Sealright Company	135
146	Seamless Rubber Company	Cover 4
147	Seven Up Company	facing page 113
148	Shampaine Company (HPF)	127
149	Simmons Company (HPF)	following page 176
150	Simonis Company	191
151	Simplex Ceiling Corporation	196

Key		Page
152	Sloan Valve Company	following page 48
55	Smith & Underwood (HPF)	10
153	Speed Queen, A Division of McGraw Edison Company	123
154	Spencer Turbine Company	188
155	Sperti-Faraday, Inc.	213
156	Squibb & Sons, Div. of Mathieson Chemical Corp., E. R.	130
157	Standard Electric Time Company	217
158	Standard X-Ray Company (HPF)	194
159	Stevens-Burt Company	196
160	Stewart & Stevenson Services, Inc.	110
161	Stromberg-Carlson Company (HPF)	194
162	Syracuse China Corp. (HPF)	following page 112
163	T & S Brass & Bronze Works, Inc. (HPF)	24
164	Thonet Industries, Inc.	221
165	Toastmaster Products Div. of McGraw-Edison Company	16
166	Travenol Laboratories, Inc.	5
167	Travenol Laboratories, Inc.	162, 163
11	Troy Laundry Machinery Division (HPF)	119
109	Union Carbide Corp., Linde Company	203
168	United States Bronze Sign Co., Inc. (HPF)	148
	Upjohn Company	86
169	Valley Metal Products Company (HPF)	165
170	Van Range Company, John	206
171	Vernon Company, Kurt	216
172	Vestal, Inc.	28, 29
173	Vinyl Plastics Incorporated (HPF)	33
174	Visi-Shelf File Inc.	219
175	Wallace Laboratories	143
176	Ward, Dreshman & Reinhardt, Inc. (HPF)	128
177	Weis Mfg. Company, Inc., Henry	following page 48
178	West Chemical Products Inc. (HPF)	25
179	White Mop Wringer Company	123
180	Will, Folsom and Smith, Inc. (HPF)	22
41	Wilmot Castle Company (HPF)	following page 32
181	Winthrop Laboratories Inc.	33
182	Zimmer Manufacturing Company	136

FIRST CLASS
PERMIT NO. 137
SEC. 34.9 P. L. & R.
CHICAGO, ILL.

BUSINESS REPLY CARD
No Postage Stamp Necessary If Mailed in the United States

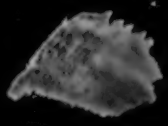
3 CENT POSTAGE WILL BE PAID BY

THE MODERN HOSPITAL

919 NORTH MICHIGAN AVENUE

CHICAGO 11, ILLINOIS

(HPF) after company name indicates that further descriptive data are filed in catalog space in Hospital Purchasing File—35th Edition.



CONTROL YOUR FOOD COSTS . . .

FRENCH CASSEROLE

SERVE UNIFORM PORTIONS *in*

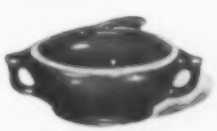
HALL
Secret Process
FIREPROOF CHINA
AVAILABLE IN 26 BEAUTIFUL COLORS

Hall Casseroles make portion control automatic. The capacity of the dish assures uniform servings of the desired size—no need to depend upon the server's skill. Hall ware also provides an opportunity to prepare economical recipes which appeal to patients. Write for Bulletin SM-1.

THE HALL CHINA COMPANY • EAST LIVERPOOL, OHIO
The World's Largest Manufacturer of Fireproof Cooking China

ROUND SHALLOW CASSEROLE

SPECIAL CASSEROLE



SAF-HANDLE CASSEROLE

INDIVIDUAL STEW POT

AN ADDED SECRET
TO THE SECRET PROCESS
HALL CHINA
METAL-CLAD...by PLATECRAFT®

Secret Process **HALL CHINA** plated with lustrous nickel-chrome by a secret process.

Write for Bulletin MC-65

H-11

Introducing **EZON**™ **DUSTING POWDER**

a superior new noninflammatory glove powder

by **SEAMLESS**

SEAMLESS—the world's foremost maker of surgical rubber gloves—announces a new biologically absorbable dusting powder.

EZON has been specifically developed to improve on all present surgical glove powders. Specially formulated from micropulverized, uniformly modified starch to provide superior lubrication, **EZON** minimizes foreign body reactions and thus the danger of adhesions.

EZON is a worthy companion to the Brown Milled, 'Crest', and 'Limber-Latex' Surgeons' Gloves by SEAMLESS—gloves that are *first* in hospital specification because they are *first* in performance.

SUPPLIED: **EZON** Dusting Powder—in packets of 1½ grams, 288 per dispenser carton, and in five-pound cans.

SURGICAL RUBBER DIVISION

THE SEAMLESS RUBBER COMPANY

NEW HAVEN 3, CONN., U. S. A.